

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>41968</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/24/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SILVER THREADS INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 E 12TH ST</b> <b>GREGORY, SD 57533</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	<p><b>Compliance Statement</b></p> <p>A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 10/24/23. Areas surveyed included resident care and potential neglect. Silver Threads Inc was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Erynn Meyerink

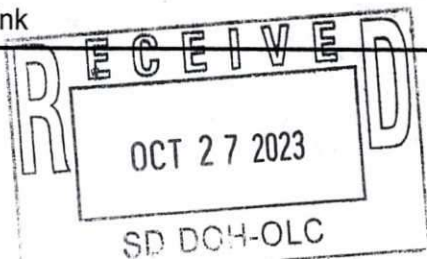
TITLE

Administrator

(X6) DATE

10/27/2023

STATE FORM



6899

PCKD11

If continuation sheet 1 of 1