DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2023 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION ING			(X3) DATE SURVEY COMPLETED		
		43G027	B. WNG_			0.	7/12/2023		
NAME OF PROVIDER OR SUPPLIER LIFESCAPE				STREET ADDRESS, CITY, STATE, ZIP CODE 2501 W 26TH ST SIOUX FALLS, SD 57105					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
W 000	INITIAL COMMENTS	3	wo	000					
	with 42 CFR Part 483 for intermediate care intellectual disabilities	tal survey for compliance 3, Subpart 1, requirements facilities for individuals with s was conducted from /23. LifeScape was found in							
*									
ABORATORY (DIRECTOR'S OR PROVIDER'S	cupplier representative's signatur Latkins	RE		CTO	7/27	(XE) D.TE		

Any deficiency statement ending with an asterisk (*) lenotes a deficiency which the institution may be excused from concelling providing it is determined that other safeguards provide sufficient protection to the patients—(See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether of not a plate of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

FORM CMS-2567(02-99) Previous Versions Obsole

L 2/ 2023

Event ID: 84M611 Facility ID: 63652

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	43G027		B. WNG			07/12/2023	
NAME OF F				STREET ADDRESS, CITY, STATE, ZIP CODE 2501 W 26TH ST SIOUX FALLS, SD 57105			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 000	A focused fundame with 42 CFR Part 4 483.73, Emergency for intermediate car intellectual disabiliti	ental survey for compliance 82, Subpart B, Subsection Preparedness, requirements e facilities for individuals with es, was conducted from 2/23. LifeScape was found in	EO				
ABORATORY D		SUPPLIER REPRESENTATIVE'S SIGNATURE	E	TITLE		(XE) DOTE	

Any deficiency statement ending will an asterist (*) lengths a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether of not a plant of deficient is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiences are cited, an approved plan of correction is requisite to continued program participation.

program participation.

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JUL 2 / 2023 | Event ID: 84M611

Facility ID: 63652

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ADMINISTRATIO N			(X3) DATE SURVEY COMPLETED	
		43G027	B. WING			07	/12/2023	
LIFESCAF	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 W 26TH ST SIOUX FALLS, SD 57105	6.20101.11002.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS		К	000				
	Life Safety Code (LSC care occupancy) was Lifescape (Building 01 found in compliance v	ey for compliance with the C) (2012 existing board and conducted on 7/12/23. 1 - Administration) was with 42 CFR 483.470 (j)(1) mediate Care Facilities for ectual Disabilities.						
		÷						
		,						
BORATORY D	RECTOR'S OR PROVIDERISE	PLIER REPRESENTATIVE'S SIGNATURE			CFO TITLE	7	X6) DATE	
ner safeguard: lowing the dat	s provide sufficient protection e of survey whether or not a ne date these documents are	nto the patients (See Instructions.) Except plan of correction is provided. For nursing	t for nursing homes, the	g hoi	excused from correcting providing it is determined the mes, the findings stated above are disclosable 90 dove findings and plans of correction are disclosable approved plan of correction is requisite to continued	ays 14		

Facility ID: 63652

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/27/2023 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING 02 - DORM COMPLETED 43G027 B. WING 07/12/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2501 W 26TH ST LIFESCAPE SIOUX FALLS, SD 57105 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) K 000 INITIAL COMMENTS K 000 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing board and care occupancy) was conducted on 7/12/23. Lifescape (Building 02 - Dorm) was found in compliance with 42 CFR 483.470 (j)(1) requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. LABORATORY DIRECT OR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Any deficiency statement ending with an asterisk (** denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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