

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>49893</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/11/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2100 N WISCONSIN MITCHELL, SD 57301</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
S 000	<p><b>Compliance Statement</b></p> <p>A complaint survey for compliance with the Administrative <u>Rules</u> of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 2/11/26. Areas surveyed included the physical environment, the staff's personal hygiene, and medication administration and destruction. Countryside Living was found in compliance.</p>	S 000	<p><b>Countryside will continue to follow our policy/procedures and continue to educate staff.</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Kathy Zoss**

TITLE

**Administrator**

(X6) DATE

**2/18/2026**