PRINTED: 08/12/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X	(3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMPLETED
		435084	B. WING			08/01/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FAULKTO	N SENIOR LIVING			1401 PEARL ST FAULKTON, SD 57438		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD I		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000		
F 583 SS=E	with 42 CFR Part 483 for Long Term Care fa 7/30/24 through 8/1/2 was found not in commodified requirements: F583 and Personal Privacy/Conc CFR(s): 483.10(h)(1)-\$483.10(h) Privacy and The resident has a right confidentiality of his confidential personal and meetings of famility this does not require the private room for each \$483.10(h)(2). The fact residents right to personal and electronic the right to send and produced in the privacy in his confidential personal and confidential personal and medical personal personal and medical personal	indentiality of Records (3)(i)(ii) and Confidentiality. In the personal privacy and repersonal and medical all privacy includes dical treatment, written and ations, personal care, visits, y and resident groups, but the facility to provide a resident.  It is must respect the conal privacy, including the or her oral (that is, spoken), a communications, including promptly receive unopened packages and other the facility for the resident, and the through a means other conal and medical records.  It is ident has a right to secure and and medical records.  It is ident to refuse the release	·	583	Arts ro	4
ABORATORY I	DIRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	9/3/	24 (X6) DATE
Brenda F	erguson			Executive Director	· 5	08/22/2024

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.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ENTIFICATION NUMBER: A. BU		E CONSTRUCTION	(X3) DATE COMF	SURVEY
	435084 B. W			l	
		WING		08/	01/2024
NAME OF PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
		1	401 PEARL ST		
FAULKTON SENIOR LIVING		F	AULKTON, SD 57438		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B. TAG REGULATORY OR LSC IDENT	BE PRECEDED BY FULL P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
			I DELIGITORY		
F 583 Continued From page 1  (ii) The facility must allow rep Office of the State Long-Term to examine a resident's medic administrative records in accel law. This REQUIREMENT is not by: Based on observation, interv review, the provider failed to and confidentiality of resident records had been maintained (licensed practical nurse (LP) nursing assistant (CNA) D, do administration. Findings inclu  1. Observation and Interview a.m. to 9:00 a.m. of one medic computer in the dining room of the waster of the medication computer so was open and displayed a resident, staff, or visitors been passing by the medication. *The unattended computer so any resident, staff, or visitors been passing by the medication. *It contained the following information of the property of the medication o	m Care Ombudsman lical, social, and cordance with State  t met as evidenced  rview, and policy of ensure the privacy of electronic health and by two of two staff  PN) C and certified during medication ude:  v 7/30/24 from 8:50 dication cart of with LPN C revealed: area and there were edication cart. coreen faced the wall, esident's electronic  screen was visible to s that would have fion cart. formation: formation: formation: formation thave been een shut. en was facing the wall	F 583	E 593	to sure all aides of not in naure sare rsing	08/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		435084	B. WING			08/	01/2024
NAME OF PROVIDER OR SUP FAULKTON SENIOR LIVE				1	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL ST FAULKTON, SD 57438		
PREFIX (EACH)	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFE TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 583 Continued Fr	om page	2	F	583			
medication or room reveale *CNA D had medications *She had wa *The medications displayed a record (MAR *The record I or visitors pa *3. Observation p.m. of one not the 200-hallw *The medication or resident's info *She was not job *100%*. *She only do and feels it is *She stated se years. *4. Interview of nursing (Dobservations *Would have the medication prior to leaving *Agreed that locked when	art compared art compared art compared are sident's local been and in a sing by an and in a sing by a sing are sident's she should are sident's art with the compared are sident's are side	y from the medication cart, outer screen was open and medication administration wisible to any resident, staff the medication cart.  Iterview on 8/1/24 at 1:41 in cart computer located in CNA D revealed: outer screen was opened ent's EMR. If y from the medication cart is room, and not have left the ine screen open with the displayed on it. If well and was not doing her aution pass once a month will enter the computer she does it. In the displayed of the computer street was not doing her aution pass once a month will enter the computer street with the displayed on it.  In the computer located in CNA D revealed: It is not have left the computer with the displayed on it. In the computer street was not doing her aution pass once a month will enter the computer street with director garding the above					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		435084	B. WING		08/01/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL ST FAULKTON, SD 57438	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 583	Privacy Practice polic *"How will this Facility information?" -" This Facility works information. We use of your health information place to keep your int by anyone that should *"Electronic health rec -"This electronic health system. This Facility system are trained to private."	that medication cart.  Is February 2019 Notice of by revealed: In protect my health  Thank to protect your health  The provider your health  The provider your information is	F 58		
F 880 SS=D	§483.80 Infection Cor The facility must estal infection prevention a designed to provide a comfortable environm development and trandiseases and infection §483.80(a) Infection program. The facility must estal and control program a minimum, the follow §483.80(a)(1) A system reporting, investigating and communicable di	ntrol blish and maintain an ind control program is safe, sanitary and ient and to help prevent the ismission of communicable ins.  prevention and control blish an infection prevention (IPCP) that must include, at ving elements:  iem for preventing, identifying, ig, and controlling infections seases for all residents, iors, and other individuals	F.88		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		435084	B. WING_			08/	01/2024
	ROVIDER OR SUPPLIER  N SENIOR LIVING			14	TREET ADDRESS, CITY, STATE, ZIP CODE 101 PEARL ST AULKTON, SD 57438		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	arrangement based used conducted according accepted national states \$483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and trant to be followed to previously when and how iso resident; including but (A) The type and dura depending upon the ininvolved, and (B) A requirement that least restrictive possibility circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit the vi)The hand hygiene by staff involved in directive actions taken \$483.80(a)(4) A systematical directive actions taken \$483.80(e) Linens.	pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify the diseases or can spread to other in possible incidents of the or infections should be insmission-based precautions ent spread of infections; thation should be used for a trial individual to a trial individual to the isolation, infectious agent or organism to the isolation should be the ole for the resident under the isolations from direct to their food, if direct the disease; and procedures to be followed the infection of the recording incidents incility's IPCP and the	F	380	1. In continuing compliance with F 880, Infection Prevention and Control, Faulkton Senior Living addressed the deficiency by ordereplacement parts for the identific equipment on 08/02/2024.  Replacement parts will be installed upon arrival by the Maintenance Supervisor.  on 08/23/2024. This corrected the exposed rusted metal and the tor cover/knee pad. All other expose rusted metal not covered by replacement parts will be coated paint by Maintenance Supervisor 09/5/2024.	ering ed ed- e m	<del>98/02/24</del> 09/12/24

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFILE	S FUR MEDICARE &	VIEDICAID SERVICES	¥		r	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		435084	B. WING		08/	01/2024
NAME OF P	ROVIDER OR SUPPLIER	7.5		STREET ADDRESS, CITY, STATE, ZIP CODE		
			1 :	1401 PEARL ST		
FAULKTO	N SENIOR LIVING			FAULKTON, SD 57438		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	infection.  §483.80(f) Annual rev The facility will condu- IPCP and update their This REQUIREMENT by: Based on observation review, the provider farmechanical lifts share were maintained in a Findings include:  1. Observation on 7/3 300-hallway revealed. *The "Volaro Full Bod that left a non-cleanal of the lift. *There was rust and s the lift's legs.  2. Observation on 7/3 "Volaro" sit-to-stand a revealed: *There was a buildup the foot base. *The knee padding wa *The foot base was m paint with exposed ru- *The right wheelbase in the rusted metal.  3. Interview on 7/31/2 revealed: *She was unsure how portions of the two lifts.	riew.  ct an annual review of its r program, as necessary.  is not met as evidenced in, interview, and policy ailed to ensure two of five ailed to ensure two of five clean and sanitary manner.  0/24 at 8:26 a.m. in the expected paint on the top of scratched paint on the top of color particles and dirt on as worn and torn.  as worn and torn.	F 880	2. To correct the deficiency and to ensure the problem does not recume chanical lifts were inspected, a parts were ordered as needed by 08/02/2024 by the Maintenance Director. The Maintenance Director and/or designee will audit all mechanical lifts for broken parts onen cleanable surfaces during environmental rounds weekly via TELS. the Director of Nursing will educate all staff that utilize lifts for patient care by 09/12/2024 on sanitizing lifts, including foot base between resident use, and to immediately notify the Director of Nursing and/or Maintenance Supervisor if a lift is damaged or hon-cleanable surfaces. The Maintenance Director and/or designee will audit all mechanical for damage and non-cleanable surfaces during environmental rounds weekly via TELS. The Director of Nursing and/or designe will audit lift sanitization between residents 3 times per week for 4 weeks, weekly for 8 weeks, and the randomly to ensure continued compliance.  3. As part of Faulkton Senior Livin ongoing commitment to quality assurance, the Maintenance Director and/or designee will report identific concerns from audits through the community's QA Process.	rall and	diser diser

(XA) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH CORRECTIVE ACTION SHOULD BE COMP D/ CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	STATEMENT OF AND PLAN OF (	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
FAULKTON SENIOR LIVING  1401 PEARL ST FAULKTON, SD 57438  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  1401 PEARL ST FAULKTON, SD 57438  ID PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP DEFICIENCY)  DEFICIENCY)  1401 PEARL ST FAULKTON, SD 57438			435084	B. WING			08/	01/2024
(XA) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH CORRECTIVE ACTION SHOULD BE COMP D/ CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					14	401 PEARL ST		
F 990	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	x	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
4. Interview on 8/1/24 at 11:26 a.m. with DON B revealect:  "No one had informed her that the mechanical lifts were damaged and needed repair.  "She would have expected all equipment would be in good working order and sanitized properly between each use.  5. Review of the provider's May 2024 General Information Prevention and Control policy.  "Procedure:  -a. All items for resident care will be cleaned and disinfected and will be designated for the resident's use only.  -i. Reducing and for preventing infections through indirect contact requires the decontamination (i.e., cleaning, sanitizing, or disinfecting an object to render it safe for handling) for resident equipment, medical devices, and the environment."  "Nursing Weekly Cleaning Tasks"  -Multiple use items will be cleaneded and disinfected between each resident use:  d. Mechanical lifts."		revealed:  *No one had informed lifts were damaged at *She would have exp be in good working of between each use.  5. Review of the provinformation Prevention *Procedure:  -a. All items for resided disinfected and will be resident's use only.  -i. Reducing and /or pindirect contact required (i.e., cleaning, sanitized to render it safe for he equipment, medical denvironment."  **Nursing Weekly Cleanultiple use items with disinfected between each same and the same and th	d her that the mechanical and needed repair. Hected all equipment would reder and sanitized properly dider's May 2024 General and Control policy.  The ent care will be cleaned and the designated for the content of the decontamination and control policy.  The ent care will be cleaned and the designated for the content of the decontamination and the decontamination	F	380			

PRINTED: 08/12/2024 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	' (		DATE SURVEY COMPLETED
		435084	B. WNG_			07/31/2024
	ROVIDER OR SUPPLIER  N SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE  1401 PEARL ST  FAULKTON, SD 57438			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		ΕC	000		
E 039 SS=C	CFR Part 482, Subpatemergency Prepared Term Care facilities we Faulkton Senior Livin compliance with the form the building will mee 2012 LSC for Existing upon correction of the E039 in conjunction volumitment to continusafety standards.  EP Testing Requirem CFR(s): 483.73(d)(2) §416.54(d)(2), §482.7 §460.84(d)(2), §482.7 §483.475(d)(2), §484.7 §485.542(d)(2), §485.7 §485.920(d)(2), §491  *[For ASCs at §416.5 at §485.727, CMHCs at §491.12, and ESRD In the SRD	the requirements of the ghealth Care Occupancies edeficiency identified at with the provider's nued compliance with the fire ents  113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), 102(d)(2), §485.68(d)(2), 102(d)(2), §485.727(d)(2), 12(d)(2), §494.62(d)(2).  14, CORFs at §485.68, REHs Organizations" under §485.920, RHCs/FQHCs at Facilities at §494.62]:  ity] must conduct exercises y plan annually. The [facility] owing: scale exercise that is ery 2 years; or not a facility-based exercise is not a facility-based functional	EC	039		
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Brenda R. Ferguson

**Executive Director** 

Facility ID: 0016

08/21/2024

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		SURVEY PLETED
		435084	B. WNG_		07	/31/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1401 PEARL ST  FAULKTON, SD 57438		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	natural or man-made activation of the emerexempt from engagin community-based or functional exercise for actual event.  (ii) Conduct an additive years, opposite the years, opposite the years, opposite the functional exercise unthis section is conducted not limited to the follotomated (A) A second full-scal community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and include a narrated, clinically-rescenario, and a set of directed messages, of designed to challenge (iii) Analyze the [facili maintain documentatic exercises, and emergifacility's] emergency  *[For Hospices at 418 (2) Testing for hospic patient's home. The learning for the second of th	emergency that requires gency plan, the [facility] is g in its next required individual, facility-based llowing the onset of the onal exercise at least every 2 ear the full-scale or inder paragraph (d)(2)(i) of ted, that may include, but is wing:  e exercise that is individual, facility-based or rill; or see or workshop that is led by les a group discussion using elevant emergency for problem statements, or prepared questions ean emergency plan.  by's] response to and on of all drills, tabletop ency events, and revise the plan, as needed.  call 13(d):]  less that provide care in the mospice must conduct emergency plan at least emust do the following:  less cale exercise that is ery 2 years; or by based exercise is not individual facility based every 2 years; or	EO	PLAN OF CORRECTION  1. In continuing compliance of E 039, EP Testing and Compliant Faulkton Senior Living address the deficiency by scheduling a resident elopement drill for 08/28/2024. An Incident Actionstarted 08/11/24.  2. To correct the deficiency as ensure the problem does not full-scale community drill will be conducted no later than July and The Maintenance Director will communicate with Faulk Countered and the Maintenance of the Will be reported by the Maintenance of the Will be reported to the Quality Committee of the Committee of the Quality Committee for any further recommendation.  3. As part of Faulkton Senior ongoing commitment to quality assurance, the Maintenance of and/or designee will report idea concerns from drills through the community's QA Process.	iace, sed In Plan Ind to recur, a se 1025. Inty Introduce a drills  Living's Introduced a drills  Director antified	08/30/24

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	
		435084	B. WING			07/	31/2024
	ROVIDER OR SUPPLIER  N SENIOR LIVING		•	140	REET ADDRESS, CITY, STATE, ZIP CODE 01 PEARL ST AULKTON, SD 57438		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	engaging in its next recommunity-based exefacility-based function onset of the emergen (ii) Conduct an additi opposite the year the exercise under paragis conducted, that mato the following:  (A) A second full-sca community-based or exercise; or  (B) A mock disaster of (C) A tabletop exercise a facilitator and include a narrated, clinically-scenario, and a set of directed messages, of designed to challenge (3) Testing for hospic care directly. The hoexercises to test the expear. The hospice mais community-based; (A) When a community accessible, conduct a facility-based function (B) If the hospice expense man-made emergency plan, engaging in its next rebased or facility-base following the onset of (ii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the onset of (iii) Conduct an addition of the emergency plan, engaging the o	the hospital is exempt from equired full scale ercise or individual hal exercise following the cy event.  onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section by include, but is not limited had exercise that is a facility based functional drill; or see or workshop that is led by the a group discussion using relevant emergency of problem statements, or prepared questions an emergency plan.  The set hat provide inpatient spice must conduct emergency plan twice per ust do the following:  The set hat provide inpatient spice must conduct emergency plan twice per ust do the following:  The set hat provide inpatient spice must conduct emergency plan twice per ust do the following:  The set hat provide inpatient spice must conduct emergency plan twice per ust do the following:  The set hat provide inpatient spice must conduct emergency plan twice per ust do the following:  The set hat provide inpatient spice must conduct emergency plan twice per ust do the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following:  The set hat provide inpatient spice with the following in the following	E	039			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII		DNSTRUCTION	(X3) DATE COMP	SURVEY LETED
		435084	B. WNG_			07/	31/2024
	ROVIDER OR SUPPLIER  N SENIOR LIVING			1401	EET ADDRESS, CITY, STATE, ZIP CODE I PEARL ST ILKTON, SD 57438		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>.</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	(A) A second full-scal community-based or exercise; or (B) A mock disaster (C) A tabletop exercifacilitator that include narrated, clinically-reland a set of problem messages, or prepare challenge an emerge (iii) Analyze the hosp maintain documentate exercises, and emerge hospice's emergency  *[For PRFTs at §441. §482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to twice per year. The [do the following: (i) Participate in an ais community-based; (A) When a community-based; (A) When a community-based function (B) If the [PRTF, Hospital actual natural or man requires activation of [facility] is exempt from required full-scale confacility-based function onset of the emerger (ii) Conduct an [	alle exercise that is a facility based functional drill; or see or workshop led by a s a group discussion using a levant emergency scenario, statements, directed ed questions designed to ncy plan. Sice's response to and ion of all drills, tabletop gency events and revise the plan, as needed.  184(d), Hospitals at §485.625(d):] FF, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must annual full-scale exercise that or ty-based exercise is not an annual individual, nal exercise; or pital, CAH] experiences an emade emergency plan, the mengaging in its next mmunity based or individual, nal exercise following the roy event. additional] annual exercise or but is not limited to the	E	039			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		435084	B. WING			07/	31/2024
	ROVIDER OR SUPPLIER			140	REET ADDRESS, CITY, STATE, ZIP CODE 11 PEARL ST ULKTON, SD 57438		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		BE .	(X5) COMPLETION DATE			
E 039	community-based or functional exercise; of (B) A mock (C) A tabletop extends a facilitator and discussion, using a nemergency scenario, statements, directed questions designed the plan.  (iii) Analyze the maintain documentate exercises, and emergency are facility's emergency are particularly. The PACE (2) Testing. The PACE exercises to test the annually. The PACE following:  (i) Participate in an ais community-based; (A) When a communaccessible, conduct a facility-based function (B) If the PACE experiment emergency plan, engaging in its next representation of the exercise following the event.  (ii) Conduct an ayears opposite the years opposite the years exercise under paragements.	individual, a facility-based or disaster drill; or kercise or workshop that is dincludes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency  [facility's] response to and cion of all drills, tabletop gency events and revise the plan, as needed.  84(d):] E organization must conduct emergency plan at least organization must do the annual full-scale exercise that or ity-based exercise is not an annual individual, anal exercise; or riences an actual natural or cy that requires activation of the PACE is exempt from equired full-scale community acility-based functional eronset of the emergency additional exercise every 2 ear the full-scale or functional graph (d)(2)(i) of this section y include, but is not limited to	E	039			

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		435084	B. WING			07/	/31/2024		
	NAME OF PROVIDER OR SUPPLIER  FAULKTON SENIOR LIVING			STREET ADDRESS 1401 PEARL ST FAULKTON, SE	S, CITY, STATE, ZIP CODE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTIC CH CORRECTIVE ACTION SHOUL S-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
E 039	community-based or functional exercise; o (B) A mock disaster (C) A tabletop exercial a facilitator and includusing a narrated, cliniscenario, and a set of directed messages, of designed to challenge (iii) Analyze the PAC maintain documentatic exercises, and emerge PACE's emergency possible that the emergency possible in an analyse to the filter of the following unannounce emergency procedures (CF/IID) must do the filter of the filt	individual, a facility based r drill; or se or workshop that is led by des a group discussion, cally-relevant emergency of problem statements, or prepared questions an emergency plan. E's response to and on of all drills, tabletop pency events and revise the lan, as needed.  It §483.73(d):] must conduct exercises to lan at least twice per year, ed staff drills using the less. The [LTC facility, following: Innual full-scale exercise that or ty-based exercise is not an annual individual, and exercise.  If facility experiences an emergency plan, the form engaging its next community-based or led functional exercise is the emergency event. In annual exercise is the emergency event. In all exercise that is an individual, facility based or led contains an individual	E	039					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		435084	B. WING		07	7/31/2024
NAME OF PROVIDER OR SUPPLIER  FAULKTON SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL ST FAULKTON, SD 57438		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 039	a facilitator includes a narrated, clinically-rel and a set of problem messages, or prepare challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emerg [LTC facility] facility's  *[For ICF/IIDs at §483 (2) Testing. The ICF/IID must do (i) Participate in an an is community-based; (A) When a community accessible, conduct a facility-based function (B) If the ICF/IID expressible, conduct a facility-based function (B) If the ICF/IID expressible, conduct a facility-based function (B) If the ICF/IID expressible, conduct a facility-based function (B) If the ICF/IID expressible, conduct a facility-based or functional exercise for emergency event. (ii) Conduct an additional include, but is not (A) A second full-sca community-based or functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and including a narrated, cliniscenario, and a set of	se or workshop that is led by a group discussion, using a evant emergency scenario, statements, directed ed questions designed to ncy plan.  I facility] facility's response to entation of all drills, tabletop gency events, and revise the emergency plan, as needed.  3.475(d)]:  ID must conduct exercises or plan at least twice per year. The following: Innual full-scale exercise that for ty-based exercise is not an annual individual, and exercise; or eriences an actual natural or exy that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based exercise that or limited to the following: le exercise that is an individual, facility-based or	E 03	9		

Event ID: VMKK21

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		435084	B. WING			07/:	31/2024
NAME OF PROVIDER OR SUPPLIER  FAULKTON SENIOR LIVING				1	TREET ADDRESS, CITY, STATE, ZIP CODE 401 PEARL ST FAULKTON, SD 57438		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	designed to challenge (iii) Analyze the ICF/I maintain documentat exercises, and emerg ICF/IID's emergency  *[For HHAs at §484.1 (d)(2) Testing. The HI to test the emergency least annually. The H (i) Participate in a full community-based; or (A) When a com accessible, conduct a facility-based function or.  (B) If the HHA e or man-made emerge of the emergency pla engaging in its next r community-based or functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under parage is conducted, that limited to the followin (A) A second full community-based or functional exercise; of (B) A mock disass (C) A tabletop ex led by a facilitator an discussion, using a n emergency scenario, statements, directed	e an emergency plan.  ID's response to and ion of all drills, tabletop gency events, and revise the plan, as needed.  O2]  HA must conduct exercises y plan at IHA must do the following: -scale exercise that is munity-based exercise is not an annual individual, nal exercise every 2 years;  experiences an actual natural ency that requires activation in, the HHA is exempt from equired full-scale individual, facility based individual, facility based exercise every 2 years, if III-scale or functional graph (d)(2)(i) of this section at may include, but is not g: -scale exercise that is an individual, facility-based or ster drill; or xercise or workshop that is	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		435084	B. WING			07/	31/2024
NAME OF PROVIDER OR SUPPLIER  FAULKTON SENIOR LIVING				1401 PE	ADDRESS, CITY, STATE, ZIP CODE ARL ST TON, SD 57438		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	documentation of all demergency events, a emergency plan, as not seem of problem statements of all demergency plan, as not seem of problem statements of a paper-based of the seem of problem statements of all demergency plan, engaging in its next refollowing the onset of (ii) Analyze the OPO documentation of all demergency plan, emergency events, a OPO's] emergency plan, emergency plan, engaging in its next refollowing the onset of (iii) Analyze the OPO' documentation of all demergency events, a OPO's] emergency plan, eme	s response to and maintain drills, tabletop exercises, and not revise the HHA's needed.  660] PO must conduct exercises or plan. The OPO must do the ased, tabletop exercise or nually. A tabletop exercise is drincludes a group arrated, clinically relevant and a set of problem messages, or prepared or challenge an emergency eriences an actual natural or by that requires activation of the OPO is exempt from equired testing exercise if the emergency event. It is response to and maintain tabletop exercises, and and revise the [RNHCI's and lan, as needed.  68]:  NHCI must conduct emergency plan. The RNHCI	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		435084	B. WING		0	7/31/2024
NAME OF PROVIDER OR SUPPLIER  FAULKTON SENIOR LIVING				STREET ADDRESS, CITY, STATE. ZIP CODE 1401 PEARL ST FAULKTON, SD 57438		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
E 039	(ii) Analyze the RNH0 maintain documentat and emergency even emergency plan, as r This REQUIREMENT by: Based on record rev provider failed to con emergency prepared include:  1. Record review on revealed no document exercise was conduct plan since July 2023.	Cl's response to and ion of all tabletop exercises, ts, and revise the RNHCl's needed.  is not met as evidenced iew and interview, the duct a full-scale exercise for ness in 2023. Findings  7/31/24 at 9:45 a.m. ntation of a full-scale ted to test the emergency	E 039			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		435084	B. WING_			07/31/2024		
	ROVIDER OR SUPPLIER  N SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE  1401 PEARL ST  FAULKTON, SD 57438					
(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 COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE			
K 000	Life Safety Code (LS occupancy) was con Senior Living was for CFR 483.90 (a) required Facilities.  The building will mee 2012 LSC for existing upon correction of deand K324 in conjunct commitment to continuately standards.	rey for compliance with the iC) (2012 existing health care ducted on 7/31/24. Faulkton and not in compliance with 42 irements for Long Term Care at the requirements of the ghealth care occupancies efficiency identified at K293 tion with the provider's nued compliance with the fire	K			(X6) DATE		
	R Ferguson			Executive Director		08/21/2024		

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.

Brenda R. Ferguson

CENTERS FU	JK MEDICAKE & MEDICAID SERVICES			At 1 Older			
STATEMENT O	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY			
			A. BUILDING: 01 - MAIN BUILDING 01	COMPLETE:			
	H ONLY A POTENTIAL FOR MINIMAL HARM			CONTEDID.			
FOR SNFs AND	INFS	435084	B. WING	7/31/2024			
	VIDER OR SUPPLIER  I SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL ST FAULKTON, SD					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN	CIES					
K 293	the emergency lighting system.  19.2.10.1 (Indicate N/A in one-story existing occur obvious.) This REQUIREMENT is not met as ev Based on observation and interview, the (storage areas and stair enclosure). Find  1. Observation on 7/31/24 at 8:45 a.m. r storage area. Two locations in the basem There was also no EXIT sign showing the Interview with the maintenance supervision.	existing occupancies with less than 30 occupants where the line of exit travel is not met as evidenced by: nterview, the provider failed to install exit signs for three locations in the basement					
K 324	Cooking Facilities CFR(s): NFPA 101  Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:  * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2  * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or  * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.  Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.  18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2						

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

The above isolated deficiencies pose no actual harm to the residents

PREFIX	
TAG	

ID

SUMMARY STATEMENT OF DEFICIENCIES

#### K 324

Continued From Page 1

FAULKTON SENIOR LIVING

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the provider failed to conduct an adequate six-month inspection or cleaning of the facility's cooking ductwork exhaust system for the range hood for calendar year 2024. Findings include:

1401 PEARL ST

FAULKTON, SD

1. Record review on 7/31/24 at 8:30 a.m. revealed the contractor's cleaning report dated 11/02/23 stated the kitchen hood exhaust system was cleaned. There was no documentation showing an internal inspection or cleaning of the exhaust ductwork and components had been performed since that date.

Interview with the maintenance supervisor on 7/31/24 at 8:40 a.m. revealed he was unaware of the ductwork six-month inspection or cleaning requirement.

The deficiency affected one the requirements for the kitchen range hood exhaust system.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED		
		10619	B. WING	B. WING		1/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
FAULKTO	N SENIOR LIVING	1401 PEA FAULKTO	RL ST ON, SD 57438			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	Compliance/Noncomp	oliance Statement	S 000			
	44:73, Nursing Facilit	of South Dakota, Article ies, was conducted from 4. Faulkton Senior Living				
\$ 000	Compliance/Noncomp	pliance Statement	S 000			
	44:74, Nurse Aide, re training programs, wa	r compliance with the of South Dakota, Article quirements for nurse aide as conducted from 7/30/24 ton Senior Living was found				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Brenda R. Ferguson

Executive Director

08/2 1/2h24