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	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	1401 PEARL ST FAULKTON, SD 57438

(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) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/30/24 through 8/1/24. Faulkton Senior Living was found not in compliance with the following requirements: F583 and F880.	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583	edits BS 9/3/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Ferguson
TITLE: Executive Director
(X6) DATE: 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.

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F 583	Continued From page 1 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the privacy and confidentiality of resident electronic health records had been maintained by two of two staff (licensed practical nurse (LPN) C and certified nursing assistant (CNA) D, during medication administration. Findings include: 1. Observation and Interview 7/30/24 from 8:50 a.m. to 9:00 a.m. of one medication cart computer in the dining room with LPN C revealed: *It was placed in the dining area and there were no staff within view of the medication cart. *The medication computer screen faced the wall, was open and displayed a resident's electronic medical record (EMR). *The unattended computer screen was visible to any resident, staff, or visitors that would have been passing by the medication cart. *It contained the following information: -The resident's name and room location. -Age and date of birth. -Gender. -Allergies. -Medical record number. *LPN C agreed the screen should not have been left open and should have been shut. *She thought since the screen was facing the wall no one would have looked at it. *She was not sure how to lock the screen. *She agreed it was a violation of Health Insurance Portability and Accountability Act (HIPAA).	F 583	F 583 PLAN OF CORRECTION 1. In continuing compliance with F 583, Personal Privacy/Confidentiality of Records, Faulkton Senior Living corrected the deficiency by providing LPN C and CNA D education on the process of locking computer screens when not in use during medication pass to ensure the privacy and confidentiality of resident electronic health records are maintained by the Director of Nursing on 08/22/2024. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses and medication aides will be educated on the process of locking computer screens when not in use during medication pass to ensure the privacy and confidentiality of resident electronic health records are maintained by the Director of Nursing on 08/30/2024. The DON and/or designee will audit for locked computer screens when not in use during medication pass weekly x 12 weeks and then randomly to ensure continued compliance. 3. As part of Faulkton Senior Living's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns from audits through the community's QA Process.	08/30/24

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F 583	Continued From page 2 2. Observation on 8/1/24 at 7:57 a.m. of one medication cart computer located in the dining room revealed: *CNA D had been in the dining area administering medications to a resident. *She had walked away from the medication cart. *The medication computer screen was open and displayed a resident's medication administration record (MAR). *The record had been visible to any resident, staff or visitors passing by the medication cart. 3. Observation and interview on 8/1/24 at 1:41 p.m. of one medication cart computer located in the 200-hallway with CNA D revealed: *The medication computer screen was opened and displayed a resident's EMR. *She had walked away from the medication cart and was in a resident's room. *She agreed she should not have left the medication cart with the screen open with the resident's information displayed on it. *She was not feeling well and was not doing her job "100%". *She only does medication pass once a month and feels it is "like new" every time she does it. *She stated she has not had re-training in 23 years. 4. Interview on 8/1/24 at 11:26 a.m. with director of nursing (DON) B regarding the above observations revealed she: *Would have expected all nurses to have locked the medication carts and the computer screen prior to leaving the medication cart unattended. *Agreed that if the computer screen was not locked when unattended resident's personal health information could have been viewed by	F 583		

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F 583	Continued From page 3 anyone walking past that medication cart. 5. Review of provider's February 2019 Notice of Privacy Practice policy revealed: *"How will this Facility protect my health information?" -" This Facility works hard to protect your health information. We use computer systems to store your health information. We have protections in place to keep your information from being seen by anyone that should not see it." *"Electronic health records/ health information" -"This electronic health record is a secure system. This Facility and the providers using the system are trained to ensure your information is private."	F 583		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		

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F 880	Continued From page 4 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880	1. In continuing compliance with F 880, Infection Prevention and Control, Faulkton Senior Living addressed the deficiency by ordering replacement parts for the identified equipment on 08/02/2024. ~~Replacement parts will be installed upon arrival by the Maintenance Superviser~~. on 08/23/2024. This corrected the exposed rusted metal and the torn cover/knee pad. All other exposed rusted metal not covered by replacement parts will be coated with paint by Maintenance Supervisor by 09/5/2024.	~~08/02/24~~ 09/12/24

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F 880	Continued From page 5 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure two of five mechanical lifts shared for multiple resident use were maintained in a clean and sanitary manner. Findings include: 1. Observation on 7/30/24 at 8:26 a.m. in the 300-hallway revealed: *The "Volaro Full Body Lift" had a torn and cover that left a non-cleanable surface area on the top of the lift. *There was rust and scratched paint on the top of the lift's legs. 2. Observation on 7/30/24 at 9:58 a.m. of the "Volaro" sit-to-stand aide lift in the 300-hallway revealed: *There was a buildup of food particles and dirt on the foot base. *The knee padding was worn and torn. *The foot base was missing several areas of paint with exposed rusted metal. *The right wheelbase of the lift had a large gouge in the rusted metal. 3. Interview on 7/31/24 at 10:42 a.m. with CNA E revealed: *She was unsure how to clean the damaged portions of the two lifts. *She was unsure if there was a policy on how to clean the lifts.	F 880	2. To correct the deficiency and to ensure the problem does not recur ~~all mechanical lifts were inspected, and 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 or non-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 has non-cleanable surfaces. The Maintenance Director and/or designee will audit all mechanical lifts for damage and non-cleanable surfaces during environmental rounds weekly via TELS. The Director of Nursing and/or designee will audit lift sanitization between residents 3 times per week for 4 weeks, weekly for 8 weeks, and then randomly to ensure continued compliance. 3. As part of Faulkton Senior Living's ongoing commitment to quality assurance, the Maintenance Director and/or designee will report identified concerns from audits through the community's QA Process.	edited BRT edited BRT 9-3-24

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F 880	Continued From page 6 4. Interview on 8/1/24 at 11:26 a.m. with DON B revealed: *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 /or 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 cleanded and disinfected between each resident use: d. Mechanical lifts."	F 880		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 7/18/24. Faulkton Senior Living was found not in compliance with the following requirement: E039. The building will meet the requirements of the 2012 LSC for Existing Health Care Occupancies upon correction of the deficiency identified at E039 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E 000		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual	E 039		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Brenda 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.

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E 039	Continued From page 1 natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of	E 039	E 039 PLAN OF CORRECTION 1. In continuing compliance with E 039, EP Testing and Compliace, Faulkton Senior Living addressed the deficiency by scheduling a resident elopement drill for 08/28/2024. An Incident Action Plan started 08/11/24. 2. To correct the deficiency and to ensure the problem does not recur, a full-scale community drill will be conducted no later than July 2025. The Maintenance Director will communicate with Faulk County Emergency Management to schedule a drill. Updates and results will be reported by the Maintenance Director monthly to the Safety Committee The results of the drills will be reported to the Quality Committee for any further recommendation. 3. As part of Faulkton Senior Living's ongoing commitment to quality assurance, the Maintenance Director and/or designee will report identified concerns from drills through the community's QA Process.	08/30/24

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E 039	Continued From page 2 the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 3 (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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E 039	Continued From page 4 community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	1401 PEARL ST FAULKTON, SD 57438

(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) COMPLETION DATE
E 039	Continued From page 5 community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	1401 PEARL ST FAULKTON, SD 57438

(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) COMPLETION DATE
E 039	Continued From page 6 (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	1401 PEARL ST FAULKTON, SD 57438

(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) COMPLETION DATE
E 039	Continued From page 7 designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	1401 PEARL ST FAULKTON, SD 57438

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E 039	Continued From page 8 plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	1401 PEARL ST FAULKTON, SD 57438

(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) COMPLETION DATE
E 039	Continued From page 9 (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to conduct a full-scale exercise for emergency preparedness in 2023. Findings include: 1. Record review on 7/31/24 at 9:45 a.m. revealed no documentation of a full-scale exercise was conducted to test the emergency plan since July 2023. Interview with the administrator on 7/18/24 at 10:00 a.m. confirmed that finding.	E 039		

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	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	**1401 PEARL ST** **FAULKTON, SD 57438**

(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) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/31/24. Faulkton Senior Living was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiency identified at K293 and K324 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

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

TITLE
Executive Director

(X6) DATE
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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	435084	A. BUILDING: **01 - MAIN BUILDING 01** B. WING	**7/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	**1401 PEARL ST FAULKTON, SD**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 293	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to install exit signs for three locations in the basement (storage areas and stair enclosure). Findings include: 1. Observation on 7/31/24 at 8:45 a.m. revealed the basement could be considered one large combustible storage area. Two locations in the basement did not have EXIT signs showing two remote paths of egress. There was also no EXIT sign showing the stair enclosure as the second path of egress. Interview with the maintenance supervisor at the time of the observations confirmed those findings. The deficiency affected three locations required to be provided with a marked and identifiable path of egress.
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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	435084	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**7/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	**1401 PEARL ST FAULKTON, SD**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 324	Continued From Page 1

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:

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10619	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	1401 PEARL ST FAULKTON, SD 57438

(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	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/30/24 through 8/1/24. Faulkton Senior Living was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/30/24 through 8/1/24. Faulkton Senior Living was found in compliance.	S 000		

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

TITLE
Executive Director

(X6) DATE
08/21/2024