PRINTED: 08/07/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		43G002	B. WING_				08/02/2023	
	NAME OF PROVIDER OR SUPPLIER SOUTH DAKOTA DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 17267 3RD ST W REDFIELD, SD 57469				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((E	PROVIDER'S PLAN OF EACH CORRECTIVE AC DSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	E ATE	(X5) COMPLETION DATE
W 000			wo	000				
	requirements for Intellatindividuals with Intellational Conducted from 7/31/	tal health survey for EFR, Part 483, Subpart 1, rmediate Care Facilities for ectual Disabilities was 23 through 8/2/23. South al Center was found in						
y								
			12					
- "								
							3	
				,				
	DIRECTOR'S OR PROVIDER/DAYA A. Abeln	SUPPLIER REPRESENTATIVE'S SIGNATUR	Director		TITLE	August	7, 2023	(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 that a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these opcurrents are made available to the facility of perioded. program participation.

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SD DOH OLC

Event-ID:FZX311

Facility ID: 11009

PRINTED: 08/07/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI			(X3) DATE SURVEY COMPLETED		
		43G002	B. WING			08/02/2023		
	NAME OF PROVIDER OR SUPPLIER SOUTH DAKOTA DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 17267 3RD ST W REDFIELD, SD 57469				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	3000	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
E 000	Emergency Prepared Intermediate Care Fa Intellectual Disabilitie 7/31/23 through 8/2/2	FR, Part 483, Subpart 1, lness requirements for cilities for Individuals with s was conducted from	E	000				
-								
	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU Direc			TITLE August 7,	2023	(X6) DATE	
Sales Sales				y be exc	cused from correcting providing it is determ	ned that		

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 than decorrection 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.

SD DOH-OLC

FORM CMS-2567(02-99) Previous Versions Obsolete AUG 0 7 20

Facility ID: 11009

PRINTED: 08/07/2023 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - COTTAGES			(X3) DATE SURVEY COMPLETED	
		43G002	B. WING			08/01/2023	
	NAME OF PROVIDER OR SUPPLIER SOUTH DAKOTA DEVELOPMENTAL CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 17267 3RD ST W REDFIELD, SD 57469		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	Life Safety Code (LSC occupancy) was cond Dakota Development Cottages) was found 483.70 (a) requireme Facilities. The building will mee 2012 LSC for existing	ey for compliance with the C) (2012 existing health care ducted on 8/1/23. South al Center (Building 04 - in compliance with 42 CFR nts for Long Term Care the requirements of the phealth care occupancies in provider's commitment to	K	0000			
	DIRECTOR'S OR PROVIDER/S Barbara A. Abeln	SUPPLIER REPRESENTATIVE'S SIGNATURE			Director	Augus	(X6) DATE t 7, 2023

Any deficiency statement ending with an asterist. (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patterns. (See instructors.) 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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Event ID: FZX321

Facility ID: 11009

If continuation sheet Page 1 of 1

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

PRINTED: 08/07/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 5	LE CONSTRUCTION 6 05 - DUPLEX	(X3) DATE SURVEY COMPLETED	
		43G002	B. WING		08/01/2023	
NAME OF PROVIDER OR SUPPLIER SOUTH DAKOTA DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 17267 3RD ST W REDFIELD, SD 57469	1 00/01/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLET	
K 000	INITIAL COMMENTS	6	K 00	0		
	Life Safety Code (LS care occupancy) was South Dakota Develor - Duplex) was found	rey for compliance with the C) (2012 existing board and a conducted on 8/1/23. The opmental Center (Building 05 in compliance with 42 CFR ements for Intermediate Care als with Intellectual				
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				3		
		ž.				
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	Directo	TITLE August 7	(X6) DATE	

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

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AUG 07 2023

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Facility ID: 11009

PRINTED: 08/07/2023 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-03
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 06 - HORIZON HOMES	(X3) DATE SURVEY COMPLETED
	43G002	B. WNG		08/01/2023
NAME OF PROVIDER OR SUPPLIER SOUTH DAKOTA DEVELOPMEN	NTAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 17267 3RD ST W REDFIELD, SD 57469	, , , , , , , , , , , , , , , , , , , ,
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
Life Safety Code (I care occupancy) w South Dakota Devi - Horizon Homes) 42 CFR 483.470 (j	arvey for compliance with the LSC) (2012 existing board and ras conducted on 8/1/23. The elopmental Center (Building 05 was found in compliance with ()(1) requirements for Facilities for Individuals with	K 000		
LABORATORY DIRECTOR'S OR PROVIDE Barbara A. Abeln	ER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Directo	TITLE August 7	(X6) DATE

SD DOH-OLC

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

PRINTED: 08/07/2023 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR WEDICARE &	VIEDICAID SERVICES				CIVID IVC	7. 0930-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED			
		43G002	B. WING			08/	01/2023
and ottomic as a second of	ROVIDER OR SUPPLIER AKOTA DEVELOPMENTA	AL CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	8889	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Life Safety Code (LS occupancy) was cond Dakota Development Damm) was found in 483.70 (a) requirement Facilities. The building will mee 2012 LSC for existing	ey for compliance with the C) (2012 existing health care ducted on 8/1/23. South al Center (Building 07 - compliance with 42 CFR ints for Long Term Care If the requirements of the ghealth care occupancies in provider's commitment to	K	000	DEFICIENCY)		
		SUPPLIER REPRESENTATIVE'S SIGNATURE	Direct	notor.	TITLE	7, 2023	(X6) DATE
Ва	rbara A. Abeln	E O E I M E N	אוט	ector	August	1, 2023	
other safegua following the o	rds provide sufficient protections	on to the patients. (See instructions.) Except a plan of correction is provided. For nursing	ept for nurs	ing home	ccused from correcting providing it is determine les, the findings stated above are disclosable 9 we findings and plans of correction are disclosal approved plan of correction is requisite to contin	0 days ole 14	

FORM CMS-2567(02-99) Previous Versions Obsolete SD DOH-OLC Event ID: FZX321

program participation.

Facility ID: 11009

PRINTED: 08/07/2023 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 08 - NORGELLO B. WING 43G002 08/01/2023

		430002	B. WING			08/0	11/2023
NAME OF PROVIDER OR SUPPLIER				8	STREET ADDRESS, CITY, STATE, ZIP CODE		
00112115	KOTA DEVEL OBLIENT	CENTER		1	17267 3RD ST W		
SOUTH DA	KOTA DEVELOPMENTA	AL CENTER		F	REDFIELD, SD 57469		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		К	000			
	Life Safety Code (LSC occupancy) was cond Dakota Developmenta Norgello) was found in	ey for compliance with the C) (2012 existing health care lucted on 8/1/23. South al Center (Building 08 - n compliance with 42 CFR onts for Long Term Care					
	2012 LSC for existing	t the requirements of the health care occupancies in provider's commitment to with the fire safety					

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

Barbara A. Abeln

Director

TITLE

(X6) DATE

August 7, 2023

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 Estructions) 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 obcurrents are made available to the facility. If periciencies are cited, an approved plan of correction is requisite to continued program participation.

AUG 0 7 2023

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Event ID: FZX321

Facility ID: 11009

PRINTED: 08/07/2023 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	##1 W/2# 0 W/1255 F300	MULTIPLE CONSTRUCTION UILDING 09 - COTTAGES TRANSITIONAL LIVING			(X3) DATE SURVEY COMPLETED	
		43G002	B. WING _			08/01/2023		
200-703-703-703	ROVIDER OR SUPPLIER	AL CENTER		17267 3RD	ORESS, CITY, STATE, ZIP CODE ST W 0, SD 57469			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS	3	K	000				
	Life Safety Code (LS care occupancy) was South Dakota Develor - Cottages Transition compliance with 42 C	rmediate Care Facilities for						
	DIRECTOR'S OR PROVIDER arbara A. Abeln	SUPPLIER REPRESENTATIVE'S SIGNATURE	D	irector	TITLE Augi	ust 7, 202	(X6) DATE	
Any deficiency other safeguar	statement ending with an areas provide sufficient protections are of survey whather or no	Lateristor denotes a deficiency which the in tion to the patients. (See instructions) Exce t a plan of correction is provided. For nursin are made available to the facility. If deficient	ept for nursing homes, the	ng homes, the to ne above finding	rom correcting providing it is determin findings stated above are disclosable gs and plans of correction are disclosa	ed that 90 days able 14		

FORM CMS-2567(02-99) Previous Versions Obsolete DOH-OLC

Event ID: FZX321

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