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

PRINTED: 02/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	0131		02/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSON CARE AND REHAB CENTER LLC	720 PARKWAY POST OFFICE BOX 486 HUDSON, SD 57034

(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 Surveyor: 27473 A first reasonable assurance health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities was conducted from 2/4/2014 through 2/5/2014. Areas reviewed were in F157, F164, F176, F226, F242, F257, F280, F281, F309, F318, F353, F354, F356, F425, F431, F441, F490, F493, F496, F514, and F520. Hudson Care and Rehab Center LLC was found in compliance for the previously cited deficiencies.	F 000		

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

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

ORIGINAL

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SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	10632		02/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSON CARE AND REHAB CENTER LLC	720 PARKWAY POST OFFICE BOX 486 HUDSON, SD 57034

(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	Initial Comments Surveyor: 27473 A first reasonable assurance survey for compliance with the Administrative Rules of South Dakota. Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/4/2014 through 2/5/2014. Areas reviewed were S145, S147, S193, S197, S198, S199, S206, S210, S236, S250, S253, S263, S278, S281, S310, S315, S323, S326, S341, S442, S445, and S460. Hudson Care and Rehab Center LLC was found in compliance for the previously cited deficiencies.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/3/14

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APR 07 2014
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