

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2016
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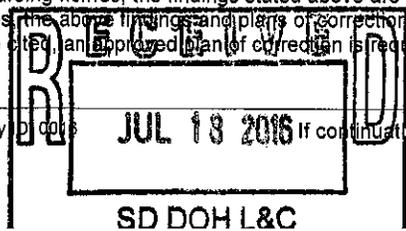
NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL ST FAULKTON, SD 57438
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F 000	INITIAL COMMENTS Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/20/16 through 6/22/16. Faulkton Senior Living was found not in compliance with the following requirements: F166, F371, and F431.	F 000	*Addendums noted with an asterisk per 7/27/16 per telephone with facility administrator. JT/SDDOHL/EL	7/14/16
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Based on interview, record review, and policy review, the provider failed to inform residents of resolutions to meal service grievances brought up in the resident council meetings from July 2015 through June 2016. Findings include: 1. Review of the resident council minutes from July 2015 through June 2016 revealed meal service grievances had been documented for eleven of twelve resident council meetings. Examples included: *On 7/4/15 Residents stated "People at tables from the first group" and "evening meal is still being served late." *On 8/11/15 Confidential resident "Wants something done about meals." *On 9/8/15 Confidential resident states "Meal time is some what to late for resident and will continue	F 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Executive Director</i>	(X6) DATE 7/15/2016
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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 166	<p>Continued From page 1</p> <p>to monitor the times of the meals and concerns." *On 12/8/15 Two residents "Upset over dining experience and nothing is being done." *On 2/9/16 "Second group did not start getting served until 6:50 PM and people from first group were still at some of the tables." *On 6/14/16 "Table served at 1:15 PM and meal service continues to be an issue." *There had been no documentation regarding the resolutions to the above concerns.</p> <p>Confidential interview on 6/21/16 at 1:30 p.m. with a group of residents who requested to be unidentified revealed three residents had been concerned and unhappy with the meal service times. Residents from the first seating had been in the dining room when it was time for the second seating. The residents had also been concerned that nothing had been done regarding their concerns with meal service.</p> <p>Interview on 6/22/16 at 2:45 p.m. with the administrator revealed: *She had been aware of the residents' concerns with the lunch and supper meal services. *She had been exploring options and tweaking the system. *There was no documentation of grievance discussions or resolutions.</p> <p>Review of the provider's undated guideline for quality improvement form revealed: **"It is the policy of this facility to respond to staff, resident/family in a timely and appropriate manner." **"The Department Head or his/her designee will investigate the concern and record the findings of the investigation as well as the action plan for the resolution on the appropriate area on the Quality</p>	F 166	<p>F 166</p> <p>This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> 1. Resident Council minutes reviewed with interdisciplinary team to assure all concerns were identified and individual concerns were addressed. 2. Executive Director attended Resident Council on 7/12/2016 reviewing recent State survey outcomes and reviewing with council how their concerns will be addressed including use of the Feedback form. 	7/14/16

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F 166	Continued From page 2 Improvement Form Follow Up." *"The Department Head is responsible for contacting the person who initiated the quality input form and providing them with feedback on the resolution of the concern within 3 working days of receiving the concern."	F 166	Concerns identified will be reviewed and discussed with resident with goal of resolution within three days.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, testing, interview, record review, manufacturer's instructions, and policy review, the provider failed to maintain sanitation with the potential of cross-contamination in the following areas: *One of one fan was blowing from a dirty to clean area in the dishwashing machine area. *Proper sanitizing of the wiping cloths during random observations in the kitchen for the food preparation area and residents' dining room tables. Findings include: 1. Observation on 6/20/16 from 3:25 p.m. through 3:55 p.m. in the kitchen revealed:	F 371	3. Interdisciplinary team is reviewing and using root cause analysis for residents dining room concerns with two meal service. ED will review each resident council minutes and identify concerns, document them on feedback form and work with individual department supervisors for resolution. Resolution will be reviewed with residents and monitoring or resolution will be in place. 4. The Executive Director or her designee will audit all resident council minutes for identified concerns, completed feedback forms and timely response and resolution monthly. The data collected will be presented to the QAPI committee at least quarterly by the Exectutive Director or her designee including any identified patterns or system failure. The committee will make the decision for further action.	

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F 371	Continued From page 3 *In the dish machine area: -There was a large fan mounted on the wall and located above the dirty end of the dish machine area. -That fan contained a moderate amount of gray, black, and tan spots with lint on the blades, was running on high, and oscillating. -It was moving air from the dirty end of the dish machine where dirty dishes and utensils were stored. -That same air was moving over the cleaned dishes and utensils stored on the clean end of the dish machine. *Testing with a napkin at the dish machine's dirty end and at the clean end counters revealed: -On the dirty end that same fan's air was blowing directly onto the dirty dishes and utensils stored there. -That same fan's air was then blowing directly onto the clean dishes and utensils on the clean end of the dish machine that were being stored there. *A green-colored bucket containing a liquid on the counter on the clean end of the three-compartment sink revealed: -There was a wet cloth located next to that bucket. -Using a Hydrion 40 test strip (a type of special paper), the liquid in the bucket tested at 600 parts per million (ppm). *Interview during the above time with cook A revealed she had used the liquid in the above bucket with the cloth to wipe down the food preparation areas. 2. Observation on 6/20/16 at 6:10 p.m. with dietary assistant B and on 6/21/16 at 11:15 a.m. with dietary assistant C revealed: *Both had been loading dirty dishes and utensils	F 371	F 371 1. The identified fan has been disconnected. The identified sanitizer dispenser was removed and replaced by VSS chemical representative on 6/29/2016 with a pre-mixed solution for use in sanitizing. 2. All fans were evaluated to assure they are clean and not creating a cross contamination. Sanitizing solution is being tested daily. 3. Dietary staff were re-educated to cleaning and sanitizing procedures and documentation on 7/14/2016. 4. Executive Director and/or her designee will audit sanitizing procedures and testing of solution, useage of fans to prevent cross contamination, completion and documentation of cleaning schedules three times weekly for one month and then two times weekly for two months. The data collected will be presented to the QAPI committee at	7/20/16

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F 371	<p>Continued From page 4 into the dish machine. *Both had been unloading clean dishes from the dish machine and placing them on the clean end of the dish machine. *The fan had been running on high and oscillating back and forth between the dirty and clean ends of the dish machine where those dishes and utensils were being stored.</p> <p>Record review on 6/22/16 of the provider's June 2016 Weekly Kitchen Cleaning List for cleaning the fan revealed: *It was scheduled for cleaning each Wednesday. *There was no documentation that showed the fan had been cleaned.</p> <p>3. Observation on 6/20/16 at 6:05 p.m. in the kitchen revealed: *Two wet cloths located next to a green-colored bucket containing liquid on the dirty end of the three-compartment sink. *Those cloths were not in a sanitizing solution when not in-use. *Using a test strip, the liquid in the bucket tested at 600 ppm.</p> <p>Interview and observation on 6/20/16 at 6:15 p.m. in the kitchen with cook A and dietary assistant D revealed: *A red-colored bucket located on the a cart used to clean off the tables in the residents' dining room contained: -A liquid with a cloth. -Using a test strip, the liquid in the bucket tested at 800 ppm. *Dietary assistant D stated she used the bucket with the cloth to wipe down the residents' dining room tables. *Both stated the kitchen had both red and</p>	F 371	<p>least quarterly by the Executive Director and or her designee including any identified patterns or system failure. The committee will make the decision for further action.</p>		

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F 371	<p>Continued From page 5</p> <p>green-colored buckets that had contained cloths used for sanitizing the following areas:</p> <ul style="list-style-type: none"> -Food preparation areas. -Residents' dining room tables. <p>*Both stated the sanitizer had needed to have been 200 to 400 ppm for proper sanitizing. *Both confirmed the sanitizer had been at 800 ppm. *Both agreed the bucket containing the sanitizer with the wiping cloth had been mixed at too high of a concentration for proper sanitizing.</p> <p>Interview and observation on 6/21/16 at 11:15 a.m. in the kitchen with dietary assistant C and at 11:35 a.m. with dietary assistant I revealed:</p> <ul style="list-style-type: none"> *A red-colored bucket located on the dirty end of the dishmachine contained a liquid and a cloth. -Using a test strip, the liquid in the bucket tested at 600 ppm. *Both stated they used the bucket with the cloth to wipe down the food production areas. *Both stated the kitchen had both red and green-colored buckets that had been used for sanitizing. *Both stated the sanitizer had needed to have been 200 to 400 ppm for proper sanitizing. *Both agreed the bucket containing the sanitizer with the wiping cloth had been mixed at too high of a concentration for proper sanitizing. <p>Observation and testing on 6/21/16 at 11:35 a.m. with dietary assistants C and I revealed the sanitizer buckets were prepared using:</p> <ul style="list-style-type: none"> *A dispenser attached to the wall located on the dirty end of the dishmachine. -That dispenser was attached to a tubing. -The tubing was connected to a five-gallon bucket marked with a label for VSS130 Disinfectant/Sanitizer. 	F 371			

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F 371	<p>Continued From page 6</p> <p>*Testing of the solution out of the dispenser revealed a level of 1000 ppm.</p> <p>*The label on the five-gallon bucket revealed: -For sanitizing non-porous surfaces that had included food countertops. -The level was to have been 200-400 ppm for proper sanitizing.</p> <p>Interview on 6/22/16 at 1:10 p.m. with cook E and dietary assistants C and B in the kitchen revealed: *There were a total of three sanitizing buckets used in the kitchen: -One was used on the residents' dining room tables. -Two were used on the food production counters in the kitchen. *They had been unsure of the proper dilution of the sanitizing buckets for proper sanitizing levels of the tables and the counters. *There had been no monitoring of the ppm levels of the sanitizing buckets containing the wiping cloths used on the above areas.</p> <p>4. Interview on 6/21/16 at 5:30 p.m. and on 6/22/16 at 2:00 p.m. with the administrator regarding the above fan in the dish machine and the sanitizing buckets and cloths used in the kitchen for wiping down the food preparation areas and the dining room tables revealed she agreed: *The fan attached to the wall in the dish room was blowing over the dirty dishes to the clean dishes and utensils stored there. *The fan should not have been blowing from dirty to clean in the dish room. *The blowing fan had a potential for cross-contamination from dirty to clean areas. *Agreed the bucket that contained the wet cloths</p>	F 371			

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F 371	Continued From page 7 used to wipe down the residents' tables in the dining room and the kitchen food production counters needed to have been at 200-400 ppm according to manufacturer's instructions. *Agreed the sanitizer had not been mixed properly and the levels had not been monitored for the correct amount of sanitizer. Review of the provider's undated product specification document of the VSS130 Disinfectant/Sanitizer revealed it: *Could be used to sanitize hard, non-porous food contact surfaces such as tables and counters. *Was an effective sanitizer on food contact surfaces when used at 200 to 400 ppm active quaternary (quat). *Was to have been exposed to surfaces as a sanitizing solution for a period of at least one minute. Review of the provider's 2008 Kitchen Cloths policy revealed cloths that were used for cleaning purposes should have been stored in sanitizing solution between uses. Review of the provider's 2008 Handling Clean Equipment and Utensils revealed: *Clean equipment and utensils were to have been handled to prevent contamination. *Those items would be stored in a clean, dry location in a way that protected them from contamination.	F 371			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431			

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F 431	<p>Continued From page 8</p> <p>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, and policy review, the provider failed to ensure narcotics and medications were properly secured for two of two medication carts. Findings include:</p>	F 431	<p>F 431</p> <ol style="list-style-type: none"> 1. The identified employee F was re-educated to locking of medication room, medication cart, narcotic storage and medication administration. 2. Procedures were reviewed regarding medication security, narcotic storage and medication administration. No other employees were identified. 3. Education will be provided to all licensed staff on 7/14/2016 by the Director of Nursing Services (DNS) and Clinical Educator in regards to medication storage, including pre-setting/pre-mixing of medication, narcotic patch storage and destruction, and security of medication carts and medication room. The identified employee F will have additional one to one education with the clinical Educator. 4. The DNS and/or her designee will three times per week, for one month and then two times per week for two months on: <p><i>*audit</i> <i>JT/SDD/H/EL</i></p>	7/14/16

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F 431	<p>Continued From page 9</p> <p>1. Observation on 6/20/16 from 6:10 p.m. to 6:42 p.m. in the medication (med) room and nurses station area with registered nurse (RN) H revealed:</p> <p>*At 6:10 p.m. he had prepared insulin and left the insulin syringes on top of the cart. -That insulin stayed on top of the cart until 6:42 p.m. when he gave it to the resident. *During that time both med carts remained unlocked at the nurses station. *At 6:15 p.m. he unlocked the med room, gathered supplies, and upon leaving he left the door open. He continued to prepare for his shift in the nurses station. *At 6:20 p.m. he went back into the med room. *At 6:26 p.m. he walked out of the med room and into the nurses station leaving the med room door open. *At 6:32 p.m. he walked back into the med room and left the med delivery person in the med room while he returned to the nurses station. *He returned to the med room at 6:33 p.m. to continue to check in medications (meds) from the delivery person. *At 6:39 p.m. he returned to the nurses station leaving the med room door open. He locked the north cart. *At 6:42 p.m. the director of nursing (DON) stood in the doorway of the med room until RN H locked the door.</p> <p>Observation on 6/22/16 at 8:20 a.m. with RN F revealed:</p> <p>*Meds were crushed and prepared in applesauce. *The med included hydrocodone (narcotic pain med). *The unidentified resident who was to get those meds was not available. *RN F put the med in the top drawer of the med</p>	F 431	<p>a. Proper narcotic storage, including patches for destruction.</p> <p>b. Proper medication administration with attention to pre-setting of medications.</p> <p>c. Medication room and medication cart security. The data collected will be presented to the QAPI committee at least quarterly by the DNS and or her designee including any identified patterns or system failure. The committee will make the decision for further action.</p>	

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F 431	<p>Continued From page 10 cart. *Meds were kept there until 8:42 a.m. with the narcotic being secured in a single-locked drawer.</p> <p>2. Interview on 6/21/16 at 11:45 a.m. with registered nurse F revealed: *Fentanyl pain patches were changed during the day shift. *Patches were taken off by the day shift nurse and then signed for destruction when the night nurse began her shift. *Patches were kept in the top drawer of the med cart that was only single-locked.</p> <p>Interview on 6/21/16 at 6:00 p.m. with registered nurse G revealed the patches were routinely kept in the top drawer of the med cart awaiting destruction by two nurses.</p> <p>3. Interview on 6/22/16 at 3:13 p.m. with the DON revealed: *Meds should not be kept on top of the med cart unattended. *Narcotics should always have been double-locked.</p> <p>Review of the January 2013 General Dose Preparation and Medication Administration policy revealed facility staff should not leave medications unattended.</p> <p>Review of the January 2013 Disposal/Destruction of Expired or Discontinued Medications policy revealed before destruction the facility should secure controlled substances under a double-lock at all times.</p>	F 431			

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

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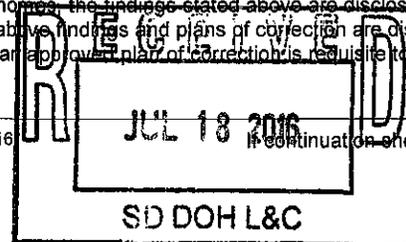
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435084	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2016
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NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL ST FAULKTON, SD 57438
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/21/16. Faulkton Senior Living (Building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiencies identified at K038, K069, and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure exits were readily available at all times. A delayed egress panic bar on the dining room exit door did not disengage with activation of the fire alarm. Findings include: 1. Observation at 1:50 p.m. on 6/21/16 revealed the dining room exit door to the outside was provided with a delayed egress panic bar. Testing of that delayed egress door during a fire drill scenario revealed the magnetic locking mechanism on that door did not deactivate. The magnetic locking mechanism for a delayed egress door shall deactivate upon activation of the building fire alarm system.	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Executive Director</i>	(X6) DATE <i>7/15/2016</i>
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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
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435084	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2016
NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 038	Continued From page 1 Interview with the maintenance supervisor at the time of the above observation and testing revealed he was unaware of that condition. He indicated he was unaware of the requirement for the door to unlock upon activation of the building fire alarm.	K 038	K 038 1. The identified delayed egress panic bar is fully functional and deactivates if the fire alarm is engaged. 2. All doors were evaluated and checked and all are fully functional. 3. Maintenance Director or the designee will test all delayed egress exits monthly for proper function including deactivation if the fire alarm is engaged. 4. The Execetutive Director and/or her designee will audit three doors monthly for full function and documentation of monthly testing is completed. The data collected will be presented to the QAPI committee at least quarterly by the Executive Director and or her designee including any identified patterns or system failure. The committee will make the decision for further action	7/20/16	
K 069 SS=D	This deficiency has the potential to affect one of five smoke compartments. NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor. 32334 Based on observation, testing, and interview, the provider failed to ensure the commercial kitchen hood ventilation system was in compliance with applicable codes. The commercial kitchen hood system was not being used during cooking operations as required by NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Findings include: 1. Observation at 11:45 a.m. on 6/21/16 in the kitchen revealed a commercial kitchen hood system over the cooking appliances. The kitchen hood exhaust was not turned on at the time of the above observation as no cooking appliances were on at that time. Testing of the exhaust fan by flipping the switch to turn it on revealed the fan created a very loud white noise. Interview with dietary staff revealed the noise was substantial enough that they often did not like to keep the exhaust system on. They indicated they sometimes would not run the fan when cooking with the gas fueled heat producing cooking	K 069			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435084	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2016
NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 147	<p>Continued From page 3</p> <p>kitchen revealed an electrical receptacle above the handsink. That was approximately one foot above the handsink. That receptacle was used to power an insect control light. Testing of that outlet with an outlet tester revealed that outlet was not protected with ground fault circuit interrupter (GFCI). Per NFPA 70 all electrical outlets within six feet of wet locations shall be GFCI protected.</p> <p>3. Observation at 12:15 p.m. on 6/21/16 in the central lounge area revealed an electrical receptacle behind the entertainment center. That duplex receptacle was used to power multiple electrical appliances for the entertainment center via a multitap adapter. Per NFPA 70 multitap adapters are not permitted.</p> <p>Interview with the administrator at 3:30 p.m. on 6/21/16 revealed she was not aware of the above conditions.</p> <p>This deficiency has the potential to affect two of five smoke compartments.</p>	K 147	<ol style="list-style-type: none"> 1. Identified electrical receptacles will be replaced by 08/10/2016. Multitap adapters will not be utilized. 2. Facility electrical receptacles were reviewed to assure no use of multitap adaptors and compliance per NFPA 70. 3. Maintenance Director has been educated and identified areas added to the TELS system for monitoring. 4. Maintenance Director and/or designee will monitor for completion of work and report to the Executive Director. Maintenance Director and/or designee will monitor monthly any new electrical work or replacement of current receptacles and for no usage of multitap adapters in the facility to assure compliance with NFPA 70. The data collected will be presented to the QAPI committee at least quarterly by the Maintenance Director and/or the designee including any identified patterns or system failure. The committee will make the decision for further action. 	8/10/16	

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

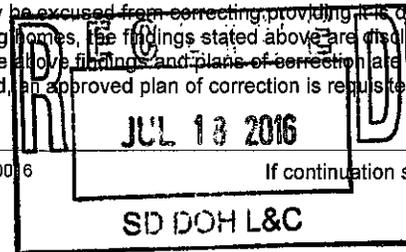
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435084	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2016
NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/21/16. Faulkton Senior Living (Building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 *Executive Director* 7/15/2016

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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PRINTED: 06/30/2016
FORM APPROVED

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10619	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2016
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NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL ST FAULKTON, SD 57438
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 32331 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 6/20/16 through 6/22/16. Faulkton Senior Living was found not in compliance with the following requirement: S296.	S 000		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits.	S 296		

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

TITLE

(X6) DATE

B. C. J.
STATE FORM

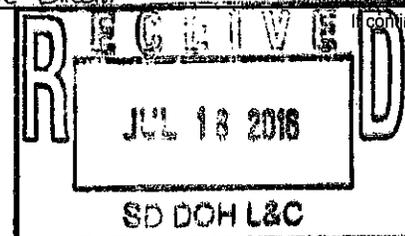
Executive Director

7/15/2016

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MVHD11

If continuation sheet 1 of 4



SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10619	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2016	
NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 296	<p>Continued From page 1</p> <p>Adequate staff whose working hours are scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and record review, the provider failed to designate a staff person to serve as the full-time dietary manager. Findings include:</p> <p>1. Observation and interview on 6/20/16 at 3:25 p.m. in the kitchen with cook A revealed: *A full-time dietary manager was not on staff at the facility. *There had not been a full-time dietary manager on staff since January 2016.</p> <p>Interview on 6/20/16 at 4:00 p.m. with the administrator revealed: *She confirmed there had not been a full-time dietary manager on staff since January 2016. *A part-time dietary manager was on staff, and she had been coming to the facility weekly. *A consultant dietitian was on contract, and she had been coming to the facility at least monthly.</p> <p>Interview on 6/21/16 at 5:30 p.m. with the administrator revealed: *The former dietary manager's last day as a full-time employee had been 12/31/15. -She had been part-time with sixteen hours or less per week since January 2016. *The provider considered full-time employment as thirty hours or more per week. *She confirmed there was not a full-time dietary manager on staff. *She agreed there needed to have been a</p>	S 296	<p>S 296</p> <p>1)Executive Director will ensure a full time Dietary Manager will be in place to meet requirements by 8/10/2016. 2) Executive Director will ensure Dietary Manager meets requirements upon hire or within required timeline. 3) Executive Director or designee will report the status of the Dietary Manager, related to achieving full compliance to S296, to the QAPI committee at least quarterly for further recommendations or input.</p>	8/10/16

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10619	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/22/2016
NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 296	<p>Continued From page 2</p> <p>full-time dietary manager on staff. *She was responsible for hiring a full-time dietary manager.</p> <p>Phone interview on 6/22/16 at 10:55 a.m. with the the former dietary manager revealed: *She had given her resignation to the provider in November 2015 *Her last day as the dietary manager was 12/31/15. *She worked part time at the facility. -She usually worked one to two hours per week. -She placed the food orders for the kitchen. *She confirmed there was not currently a full-time dietary manager assigned to be in charge of the dietary department.</p> <p>Review of the provider's 1/1/16 Change of Status form for the former dietary employee revealed: *She was scheduled for part-time. *Part-time employment was less than sixteen hours per week.</p> <p>Review of the provider's undated Job Description and Essential Functions for the dietary manager revealed: *The following essential duties had included: -Hire, orientate, train, evaluate, and supervise dietary employees. -Schedule and assign dietary employees. -Provide nutritious, well prepared, and well presented meals on a timely and consistent basis. -Inspect food, food preparation, and storage areas to ensure compliance with state requirements. -Review residents' diet information and care plans. -Order all dietary supplies, utensils, and food. -Plan menu changes to ensure all changes</p>	S 296		

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10619	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/22/2016
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NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL ST FAULKTON, SD 57438
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 296	Continued From page 3 conform to nutritional standards. -Comply with standards established by the quality assurance program. *The dietary manager reported to the administrator.	S 296		
S 000	Compliance/Noncompliance Statement Surveyor: 32331 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 6/20/16 through 6/22/16. Faulkton Senior Living was found in compliance.	S 000		