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

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CILA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>436050</td>
<td>A. BUILDING</td>
<td>03/15/2018</td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
<td></td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**  
ARLINGTON CARE AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
120 CARE CENTER ROAD  POST OFFICE BOX 280  
ARLINGTON, SD 57212

<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X6) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Surveyor: 37545
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/13/18 through 3/15/18. Arlington Care and Rehabilitation Center was found in compliance.

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**LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**  
Terry Wieck

**TITLE**  
Administrator

**DATE**  
3/27/18

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 discloseable 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 discloseable 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.
Surveyor: 14160
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/13/18. Arlington Care and Rehabilitation Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.

The building will meet the requirements of the 2012 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.

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 discloseable 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 discloseable 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**

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<th>(X) MULTIPLE CONSTRUCTION</th>
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<tr>
<td>435050</td>
<td>A. BUILDING</td>
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**NAME OF PROVIDER OR SUPPLIER**

**ARLINGTON CARE AND REHABILITATION CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

120 CARE CENTER ROAD  
POST OFFICE BOX 280  
ARLINGTON, SD 57212

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**ID PREFIX TAG**  
**SUMMARY STATEMENT OF DEFICIENCIES**  
**E 000**  
Initial Comments

Surveyor: 37545  
An initial survey for compliance with all Federal emergency preparedness requirements was conducted from 3/13/18 through 3/15/18.  
Arlington Care and Rehabilitation Center was found in compliance with 42 CFR Part 483.73 requirements.

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**ID PREFIX TAG**  
**PROVIDER'S PLAN OF CORRECTION**  
**E 000**

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

Terry Rieck  
Administrator  
3/27/18

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*Any deficiency statement ending with an asterisk (*) denotes a deficiency which in the institution may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patient. (See instructions.) Except for nursing homes, the findings stated above are dischargeable 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 dischargeable 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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**FORM CMS-2867(02-99) Previous Versions Obsolete**  
**Event ID: 156211**  
**Facility ID: 0036**  
If continuation sheet Page 1 of 1
### Compliance/Noncompliance Statement

Surveyor: 37545  
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/13/18 through 3/15/18. Arlington Care and Rehabilitation Center was found in compliance.

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### Compliance/Noncompliance Statement

Surveyor: 37545  
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 3/13/18 through 3/15/18. Arlington Care and Rehabilitation Center was found in compliance.