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

PRINTED: 11/30/2020 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED   |                              |                            |
|--|--|--|--|--|---|------------------------------|----------------------------|
| 435084   |  | B. WING  |  |  | 11/18/2020  |                              |                            |
| NAME OF PROVIDER OR SUPPLIER  FAULKTON SENIOR LIVING |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE  1401 PEARL ST  FAULKTON, SD 57438 |   |                              |                            |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG                    | ×  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                              | (X5)<br>COMPLETION<br>DATE |
| F 000  | INITIAL COMMENTS   |  | F 000                                  |  |   | SELECTION TO SELECTION TO SE |                            |
|  | Surveyor: 42477  |  |  |  | и   |                              |                            |
|  | was conducted by the of Health Licensure at 11/18/20. Faulkton Secompliance with 42 C rights and 42 CFR Paregulations: F550, F56 F882, F885, and F886 Faulkton Senior Living | Infection Control Survey South Dakota Department and Certification Office on enior Living was found in FR Part 483.10 resident art 483.80 infection control 62, F563, F583, F880, 6. g was found in compliance 7.73 related to E-0024(b)(6). |  |  |   |                              |                            |
|  |  |  |  |  |   |                              |                            |
|  |  |  |  |  |   |                              |                            |
| .ABORATORY I   | DIRECTOR'S OR PROVIDER/S   | 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.

FORM CMS-2567(02-99) Previous Versions Obsolete (1) 3 0 2020 Event ID: DOF9

Brenda R. Ferguson

**Executive Director** 

11/30/2020