STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING _____ B. WING _____	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	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
F 000	INITIAL COMMENTS Surveyor: 06365 A recertification and complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/15/22 through 2/17/22. Faulkton Senior Living was found not in compliance with the following requirement: F636. A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/15/22 through 2/17/22. Areas surveyed included Quality of Care/Treatment and Nursing Services. Faulkton Senior Living was found in compliance.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 636	F 636 PLAN OF CORRECTION ~~Faulkton Senior Living denies it violated any Federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.~~ 1. In continuing compliance with F 636, Resident Assessment; Faulkton Senior Living corrected the deficiency by reviewing and updating the physical device assessments for residents 18, 15~~, and~~ all ~~like~~ residents. MDSC corrected resident 18's MDS dated 2/8/22 to include motion sensor on 3/10/22. reviewed to determine need for updated physical device assessment. 3/20/22 BRF	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda R. Ferguson	Executive Director	03/13/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING _____ B. WING _____	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	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
F 636	Continued From page 1 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 636	2. To correct the deficiency and to ensure the problem does not recur Minimum Data Set Coordinator was educated on Physical Device Assessment and MDS section P coding by Director of Nursing on 2/17/2022. The Director of Nursing and/or designee will audit 3 residents with ~~3~~ Physical Device ~~Assessments~~ weekly for 4 weeks, monthly for 2 months, ~~and randomly~~ to ensure continued compliance. The Director of Nursing and/or designee will audit section P of 3 MDS's weekly for 4 weeks, monthly for 2 months, ~~and then randomly~~ to ensure continued compliance. 3. As part of Faulkton Senior Living's ongoing commitment to quality assurance, the Director of Nursing Services and/or designee will report identified concerns from audits through the community's QA Process. 4. The Director of Nursing is responsible for this area of compliance.	03/13/2022 BH 3/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING _____ B. WING _____	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	1401 PEARL ST FAULKTON, SD 57438

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F 636	Continued From page 2 Surveyor: 06365 Based on observation, interview, record review, and policy review, the provider failed to assess fall prevention devices for 2 of 3 (15 and 18) sampled residents with devices. Findings include: 1. Observation and interview on 2/16/22 at 11:00 a.m. with resident 18 revealed: *She was seated in a reclining chair with her legs extended on the footrest and was using an oxygen concentrator. *She reported she had been in the hospital several times since she moved in and thought it was due to problems with her breathing. Observation and interview on 2/16/22 at 12:43 p.m. revealed: *Certified nursing assistant (CNA) J provided weight-bearing assistance while transferring resident 18 from her recliner to her wheelchair and then onto the toilet. *While the resident was seated on the toilet, CNA J moved an alarm pad from the seat of the recliner to the seat of the wheelchair. *The alarm sounded momentarily when the resident transferred off the recliner, and then when she sat down in her wheelchair. *CNA J explained the alarm sounds at times of transfer to confirm it is turned on and working, but staff received all other alarm sounds on their pagers when the resident was moving. Review of the progress notes in the electronic medical record (EMR) for resident 18 revealed: *On 11/30/21, she was admitted to the facility. *On 12/6/21, she was sent to the hospital with an injury that happened when the resident was "rolling/sliding out of bed." *On 12/9/21, she returned to the facility, and a fall	F 636		

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F 636	Continued From page 3 risk summary scored her as "high risk." *On 12/10/21, a care conference noted a discussion of the resident's fall history and plans for fall prevention with multiple family members. *On 12/11/21, the resident was "educated to use her call light" but "doesn't remember to use it at this point. She tends to yell...to get staff members attention." *On 12/14/21, a physical device evaluation noted the use of a "hi-low bed" in a low position was appropriate because the "resident does not always remember to call for assistance," and "she does not seem to want to get out of her [reclining] chair" when her wheelchair and walker "are not close enough to use." *On 1/23/22, the resident was found on the floor next to the toilet in her room with her bottom exposed and a bump on the back of her head. *On 1/24/22, a post-fall intervention was noted as "Do not leave unattended in bathroom." Another note documented a conversation with the resident's power of attorney included: -"Options to prevent falls, including moving her to a room closer to the nurse's station." -A discussion that "most interventions are to prevent injuries as it is not feasible to expect we can prevent every fall." Review of the care plan, initiated on 11/30/21 and revised on 12/6/21, revealed: *"At risk for falls r/t [related to] limited physical mobility and weakness." *An intervention for "wide bed with pillow under sheet when in bed. Bed low to the floor." *Interventions added on 1/24/22 included: -"Do not leave unattended in the bathroom." -Use an "alarm pad under [resident] at all times in her bed, recliner, & w/c [and wheelchair]."	F 636		

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	435084	A. BUILDING _____ B. WING _____	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	1401 PEARL ST FAULKTON, SD 57438

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F 636	Continued From page 4 Review of the physical device evaluation dated 2/1/22 revealed: *Locomotion devices included wheeled walker and wheelchair. *The "Other" option was not checked under the section for "Other devices." Instead, "None of the above" was checked. *Medical symptoms and diagnosis list included: -Sensory and cognitive deficits, impaired judgment, unaware of boundaries, impulsive and self-injurious behavior, impaired mobility and weakness, and frequent falls. -Arthritis, stroke ("CVA"), and dementia. *The section for "Interventions" was left blank. *The summary section indicated the "device will be used for" mobility, positioning, safety, resident preference. *There was no rationale documented for the use of the chair and bed alarms nor how the alarms could or did affect the resident's movement. Review of the 2/8/22 comprehensive Minimum Data Set (MDS) assessment revealed: *Bed and chair alarms were coded as "not used." *The fall history noted that a fall occurred in the last month and in the last 2-6 months. *Resident 18's diagnosis list included dementia, "cardiorespiratory conditions," and "restlessness and agitation." *She needed extensive weight-bearing activities of daily living (ADL) assistance to transfer between surfaces. *Her mental status was cognitively intact, but she displayed behavioral symptoms that significantly interfered with the resident's participation in activities or interactions with others. Review of the 2/8/22 care area assessments (CAA) for the comprehensive MDS revealed:	F 636		

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	435084	A. BUILDING _____ B. WING _____	C 02/17/2022

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F 636	Continued From page 5 *The behavioral symptoms CAA noted resident 18 was disruptive and "yelling out" and had "one episode of hallucinations/delusions" that was "associated with Sundowners." *The ADL functional potential CAA noted her functional abilities were impacted by her behavioral symptoms, recent falls due to the risk factors of weakness and poor balance. *The falls CAA noted a "history of falls with several since admission" with risks factors including weakness and dizziness from "poor oxygenation." On 2/16/22, a written request form for documents, including the policies and procedures for fall prevention and physical restraints, was provided to administrator A. Review of the written request form and the documents provided revealed: *The fall risk and prevention guidelines, revised in February 2019, did not address the assessment of fall prevention devices. *The note, "(Don't have one/[do not] use restraints)" was written on the request form next to the requested restraint policy and procedure. Interview on 2/17/22 with MDS coordinator C did not occur as she was involved with the care conferences. Interview on 2/17/22 at 1:58 p.m. with director of nursing B revealed: *There were no documented assessments for the use of the chair and bed alarms because they had not restricted her movement. *She acknowledged they could have been addressed on the physical device evaluation. *The fall on 1/23/22 occurred when the resident "impulsively tried to get up [from the toilet] when	F 636		

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	436084	A. BUILDING _____ B. WING _____	C 02/17/2022

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F 636	Continued From page 6 she was done [going to the bathroom]." *The fall could have been prevented if the CNA who had assisted the resident onto the toilet had not left her there to answer a call for help from another CNA. 2. Observation on 2/17/22 at 3:01 p.m. of resident 15 revealed: *She was lying on her bed that was low to the floor with a raised edge mattress. *She had both of her legs resting on top of the raised edge. *The resident was awake and spoke with a strongly tremulous (quivering) voice that made it very difficult to understand what she said. Review of the care plan, initiated on 1/23/20 and revised on 11/15/21, revealed the interventions for the resident's fall risk included: *Bed in "low position at all times." *"Lip mattress on bed." *"Rocking w/c [wheelchair] for positioning and fall prevention. Review of the physical device evaluation dated 12/8/21 revealed: *"Hi-low" bed was the only bed device checked. "Scoop type mattress" was not checked. *Wheelchair was the only locomotion or chair device checked. The rocking wheelchair was not noted. *The "Other" option was not checked under the section for "Other devices." Instead, "None of the above" was checked. *The section for "Interventions" was left blank. *The summary section indicated the "device will be used for" positioning, safety, and resident preference.	F 636		

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F 636	Continued From page 7 Review of the 12/21/21 MDS revealed: *No physical restraint options were coded as used. *There had been no falls since the prior assessment. *She needed extensive weight-bearing activities of daily living (ADL) assistance to transfer between surfaces and was totally dependent for mobility in her wheelchair. *She had not wandered nor displayed any behavioral symptoms.	F 636		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING _____ B. WING _____	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	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
E 000	Initial Comments Surveyor: 06365 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 2/15/22 through 2/17/22. Faulkton Senior Living was found in compliance.	E 000		

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

Brenda R. Ferguson | Executive Director | 03/11/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	**1401 PEARL ST** **FAULKTON, SD 57438**

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/17/22. Faulkton Senior Living 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 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

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

Brenda R. Ferguson | Executive Director | 03/11/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10619	A. BUILDING: _____ B. WING _____	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	1401 PEARL ST FAULKTON, SD 57438

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S 000	Compliance/Noncompliance Statement Surveyor: 06365 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/15/22 through 2/17/22. Faulkton Senior Living was found not in compliance with the following requirement: S206.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206 S206 BRF 3/20/22	S (~~296~~) 206 PLAN OF CORRECTION ~~Faulkton Senior Living denies it violated any state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.~~ BRF 3/20/22 1. In continuing compliance with ~~S 296~~, Personnel training, Faulkton Senior Living corrected the deficiency by ensuring personnel training for employees E, F, G, H, I and all ~~like~~ employees will be completed by 3/31/2022. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 03/16/2022 on ensuring required personnel training is completed timely by Executive Director. The Staff Development Director and/or designee will	04/08/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda R. Ferguson — TITLE: Executive Director — (X6) DATE: 03/13/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10619	A. BUILDING: _____ B. WING _____	02/17/2022

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S 206	Continued From page 1 Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 06365 Based on interview and review of employee files and personnel training transcripts, the provider failed to ensure five of five (E, F, G. H. and I) employees had completed the required training subjects during orientation or annually. Findings include: 1. Review of files and personnel training transcripts showing completion of the required subjects during the past year revealed: *Dietary aide E, hired on 12/31/21, had not completed fire prevention, proper use of restraints, and diseases subject to mandatory reporting. *Certified nursing assistant F, hired on 1/10/22, had not completed fire prevention, proper use of restraints, and diseases subject to mandatory reporting, and abuse and neglect. *Licensed practical nurse G, hired on 5/5/20, had not completed fire prevention, emergency procedures, proper use of restraints, confidentiality, and diseases subject to mandatory reporting. *Nursing assistant H, hired on 11/11/21, had not completed fire prevention, proper use of restraints, and diseases subject to mandatory reporting. *Environmental services director I, hired on 8/15/17, had not completed proper use of restraints and diseases subject to mandatory reporting. Interview on 2/17/22 at 1:40 p.m. with administrator A revealed there had not been a	S 206	audit personnel training completion weekly for 4 weeks, monthly for 2 months, ~~and randomly~~ to ensure continued compliance. 3. As part of Faulkton Senior Living's ongoing commitment to quality assurance, the Staff Development and/or designee will report identified concerns through the community's QA Process. from audits 4. The Executive Director is responsible for this area of compliance.	3/20/22 BAT

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10619	A. BUILDING: _____ B. WING _____	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 206	Continued From page 2 focus on tracking the completion of required training subjects.	S 206		
S 000	Compliance/Noncompliance Statement Surveyor: 06365 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 2/15/22 through 2/17/22. Faulkton Senior Living was found in compliance.	S 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10619	A. BUILDING: _____ B. WING _____	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	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 206	Continued From page 2 focus on tracking the completion of required training subjects.	S 206		
S 000	Compliance/Noncompliance Statement Surveyor: 06365 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 2/15/22 through 2/17/22. Faulkton Senior Living was found in compliance.	S 000		