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	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Faulkton Senior Living	1401 Pearl St Faulkton, SD 57438

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and policy review, the provider failed to ensure medications were securely stored and labeled for safe use according to professional standards to ensure:*One of two medication carts (the cart used by certified medication aide) were locked when unattended by one of one certified medication aide (F).*Insulin pens for three of eight sampled residents (11, 14, 43) were dated when opened to ensure they were used according to manufacturers' instructions.*One of one medication rooms was free from expired prescription medications and supplies. *One of one refrigerator in the medication room that contained a controlled medication (medication at risk for addiction) was locked. Findings include:1. Observation and interview on 12/11/25 at 8:15 a.m. with certified medication aide (CMA) F revealed: *She left the medication cart unlocked and unattended, went to the storeroom, and then returned to the cart with a medication. *She left the medication cart unlocked and unattended, went into a resident's room, and then returned to the cart.*Upon interview, she verified she should have locked the medication cart before leaving it unattended to ensure the medications were secured. *In the medication cart there was a Lantus insulin pen for resident 43 that did not have an open or expiration date written on it, to ensure it was used according to manufacturers' instructions. 2. Observation and interview on 12/11/25 at 9:57 a.m. with registered nurse (RN) E in the medication supply room, and of her assigned medication cart revealed: *In the medication room, there was a box of approximately 100 hypodermic needles that expired on 10/1/23. *In the medication room, there was a bottle of resident 13's 300mg gabapentin that expired on 9/11/25. *In the medication room, the unlocked emergency monoclonal antibody reaction kit contained oral Benadryl (a medication used when someone had allergy symptoms) that had expired on 3/25/23, an albuterol inhaler (an inhaled medication used when muscles in your breathing tubes tightened) that had expired on 2/2024, IV (intravenous) solumedrol (a medication given to reduce swelling and inflammation) that had expired on 6/7/25, an epinephrine pen (an emergency medication given when someone had a severe allergic reaction) that had expired in December 2023, and IV Benadryl that expired in April 2024. *RN E verified that expired medications may not be as effective if they were to be used for the residents. *RN E stated that the emergency kit had not been used for years, and the pharmacy was to remove it when the other emergency kits medications were exchanged. *The medication room was to be checked for outdated medications and supplies weekly, on the weekend, by a nurse or a medication aide. *The refrigerator had a lock on it that was unlocked. There was lorazepam (a controlled anxiety medication) inside of it.*In the medication cart assigned to RN E, there was a Basaglar insulin pen for resident 11 and a Humulin insulin pen for resident 14 that did not have an open or expiration date to ensure they were used according to manufacturers' instructions. 3. Interview on 12/11/25 at 11:45 a.m. with director of nursing (DON) B revealed:*She expected CMA F to lock the medication cart when it was unattended.*She expected insulin, a medication with a shortened expiration date (medication that, after opening, expired prior to the manufacturer's expiration date) to be dated when it was opened to know when it should be discarded or removed from the cart, so it was not available for use.*She expected the weekend night shift (continued on next page)

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.

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurses to check the medication room for expired medications and supplies and to document when that check was completed. *She expected the refrigerator to be locked if there was a controlled medication inside of it to ensure it was secured properly. *The pharmacy was supposed to remove the emergency monoclonal antibody reaction kit from their facility because they no longer used it. 4. According to the Lantus manufacturer's instructions, the medication should be discarded after being open for 28 days, even if it still has insulin in it. 5. According to the Basaglar manufacturer's instructions, the medication should be discarded after being opened for 28 days. 6. According to the Humulin manufacturer's instructions, the medication should be discarded after being opened for 28 days. 7. Review of the provider's 12/3/25 Medication Administration policy revealed:* Identify expiration date. If expired, notify nurse manager. 8. Review of the provider's 11/18/25 Controlled Substances policy revealed:* NOTE: THE NARCOTICS SUPPLY IS TO BE KEPT UNDER TWO LOCKS AT ALL TIMES. THE LOCK ON THE MEDICATION CART AND THE LOCK ON THE NARCOTICS DRAWER ARE TO BE LOCKED AT ALL TIMES. IF THE CART IS KEPT IN A MEDICATION ROOM, THE MEDICATION ROOM IS TO BE LOCKED AT ALL TIMES.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the provider failed to ensure complaints of potential abuse were investigated and reported to the facility leadership and the South Dakota Department of Health (SD DOH) for one of one sampled resident (7) who reported concerns of two different staff members (unidentified nurse and certified nursing assistant (CNA) H) handling her roughly during care. Findings include: 1. Observation and interview on 12/9/25 at 11:50 a.m. and 12/9/25 at 12:10 p.m. in resident 7's room revealed:*She was sitting in a broda wheelchair (a specialized wheelchair that can be reclined) applying lip gloss.*She reported that a travel staff member was rough with her, pushed her, and talked meanly to her when assisting her. She was unsure what that staff person's name was, but described her as having colored skin and said she put her to bed at night sometimes.*When asked if she told anyone she said the nursing home was short of help, so she did not think they would fire anyone, she did not want anyone to get mad at her, and her daughter did not believe her. 2. Review of resident 7's electronic medical record (EMR) revealed:*She was admitted on [DATE].*Her 10/20/25 Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated her cognition was moderately impaired. *She had diagnoses of unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities) and major depressive disorder (a serious mood disorder causing persistent sadness and loss of interest in activities, significantly impacting daily life). *Her 10/28/25 care plan indicated she required the assistance of two staff members to transfer into bed using a total body lift (a mechanical lift and sling used to lift a person's full body), the staff were to be patient with her as she talked quietly and slowly, and she was considered a vulnerable adult due to having dementia with poor decision-making abilities and the need for assistance with her activities of daily living.*There were progress notes that resident 7 refused medications and was aggressive with staff at times. *A 5/22/25 care conference note indicated resident 7's daughter, MDS coordinator/registered nurse (RN) G, and social worker (SW) C attended the meeting. Resident 7 had some behaviors with hitting and swearing, and did not have any cognitive changes. Resident 7's daughter reported concerns about a staff member who did not use a sling, picked up the resident, and set her down roughly. *An 11/6/25 care conference note indicated resident 7's daughter, MDS coordinator/RN G, SW C, activity staff, and dietary staff attended the meeting. The note indicated that the resident refused care, hit, bit, and kicked at staff members at times. The note indicated there was a complaint that resident 7 sat out in the dining room or solarium too long, it had been a regular complaint of hers, and it would be addressed with the staff. *There was no documentation that indicated any follow-up or discussion of the potential abuse allegations the residents' daughter reported during the 5/22/25 care conference occurred. 3. Interview on 12/10/25 11:40 a.m. with administrator A revealed:*If a complaint was reported, nursing staff would document it in the nursing notes in that resident's EMR, and if they were not able to correct the issue, then the grievance form would be filled out. *If a grievance form was filled out, it would be given to the charge nurse or the director of nursing (DON), and then it would be given to her for review. *No grievance forms had been filled out in the last six months. *If she found that there was a frequent complaint, she reported that to the interdisciplinary team (IDT) meeting for discussion. *Residents were educated on how to file a grievance at the resident council meeting and could share complaints at those meetings. 4. Interview on 12/10/25 at 2:05 p.m. with certified nursing assistant (CNA) I revealed: *Resident 7 had complained to her about a traveling staff member being rough with her around three weeks ago. At that time, she saw a red spot on resident 7's left side of her forehead, and CNA I thought that the staff person was travel CNA H.*CNA I explained that when CNAs repositioned resident 7 in bed, sometimes the residents head would bump on the wall if they were not careful due to how the resident was positioned. *She indicated that if the staff would not rush when working with resident 7, it would be better for the resident.*She reported resident 7's concerns and the red spot on her (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forehead to registered nurse (RN) J and licensed practical nurse (LPN) D right away.*No other residents had complained to her about a staff member being rough with them. 5. Interview on 12/10/25 at 2:08 p.m. with DON B revealed:*She had not heard any complaints about staff being rough with resident 7. She remembered resident 7 saying someone was rough with her, and recalled that an investigation was not warranted, and was unable to explain further. *DON B stated that resident 7 likes to be the boss and it's my way or the highway type of person. *DON B stated resident 7 had it out for a traveler [travel staff] staff member months ago, who was no longer working there. *She remembered a while ago that resident 7's daughter reported something about a staff member who left the residents pop out of her reach, but did not recall hearing anything about the staff member being rough. *If a resident made a complaint to a CNA, she expected that CNA to tell the charge nurse immediately.*She expected the charge nurse to make sure the resident was safe, reassign that CNA from working with residents, if warranted, and then to call her.*She reported she reviewed her daily staff clinical meeting notes, and she did not find any documented incidents regarding resident 7 and a staff member being rough with her in those notes.*There were no incidents or complaint reports filed regarding resident 7's complaints. *Staff had to assist resident 7 carefully; otherwise, she did not like it and would complain. *DON B called social worker (SW) C during the interview to see if she had heard of the incident of a staff member being rough with resident 7. SW C reported to DON B that resident 7's daughter reported a concern during a care conference that resident 7 was left in the dining room for a long period of time, but nothing about a staff member being rough with her. *DON B was unsure what was done to follow up on that complaint, as MDS coordinator/RN G attended the care conferences, and she must have looked into that complaint and did not find any reason to notify her of it. 6. Interview on 12/10/25 at 2:35 p.m. with MDS coordinator/RN G revealed:*Resident 7's daughter had reported to her in the past that a night shift staff member was rough with her, did not give her the name of that staff member, so they were not able to do anything about it.*Resident 7 had made accusations about a travel staff member who had colored skin in the past, around three to six months ago. Since then, during care conferences, she asked resident 7's daughter if resident 7 had reported any further instances of staff being rough with her. -There was no documentation that an investigation was completed.*She helped staff assist resident 7 with transfers several times, and the resident verbalized pain when transferred, even though the staff were being careful with her. 7. Interview and EMR review on 12/10/25 at 2:50 p.m. with SW C revealed:*She was the grievance counselor.*If a resident reported a complaint to a staff member, the staff member was to verbally tell her, their supervisor, the DON, the administrator, or the department head the complaint was related, or they could fill out the grievance form. *If someone reported a complaint to her, she would complete an assessment and make a progress note in the resident's chart.*If a grievance form was filled out, she would give it to the department manager it was related to, keep a copy of it, and it would then be scanned into the resident's chart.*She had not received any grievance forms since she started at the facility in March 2025.*At resident 7's last care conference, she thought resident 7's daughter complained about the resident being left in the dining room for a long period of time and about a wheelchair cushion. *She stated that the complaint during the 5/22/25 care conference, which SW C and MDS coordinator/RN G attended, was regarding a male nursing staff member whom resident 7 did not like. He picked her up without a sling and set her down roughly. The care conference note indicated that resident 7 stated, I don't want them mad at me, and the daughter reported that resident 7 feared retaliation. *The male staff member whom resident 7's complaint was about was talked to about the incident, and he no longer worked at the facility.*When reviewing resident 7's EMR, she was not able to find a progress note regarding what follow-up was done with the incident reported on 5/22/25 during the care conference.*The DON should have been notified about resident 7's complaint, since it had been regarding a nursing situation, and administrator A should have been notified. 8. Interview on 12/10/25 at 3:15 pm. with LPN D revealed:*Several weeks ago, CNA I reported to LPN D that resident 7 told her that a staff member was rough with her, and CNA I observed a red mark on the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right side of the resident's forehead.*At the time CNA I reported that to her, she was busy, so she talked to resident 7 later that day. Resident 7 was not able to tell her anything about the incident, and LPN D did not observe a red spot on resident 7's forehead at that time. *LPN D stated that CNA I was good about reporting that kind of stuff.*LPN D did not report resident 7's complaint or CNA I's reported observation of a red spot on the residents forehead to anyone else since she did not see the red spot, and resident 7 was not able to recall the incident. *She thought she had charted her investigation in the residents' EMR.*She explained she thought resident 7's complaint was resident 7 being resident 7, and that resident 7 would say something and then later say something different. *If a CNA reported a resident's complaint to her, she would check on the resident and see what they said about it. If they reiterated the complaint to her, then she would notify the DON or the administrator about it. *She did not receive other reports or complaints about staff being rough with residents.*She had overheard other staff talking about travel CNA H being rough with residents during her last assignment to work at this facility, but not during CNA H's most current assignment. *She witnessed CNA H become upset with a confused resident. She asked her to step out of the room, and she found another CNA to take over the care of that resident. *After CNA H took a break, she was able to work with that resident again without issue. *She reported the incident regarding asking CNA H to leave the room to the DON a while ago.*CNA H currently worked at the facility.*She thought there was a communication issue between CNA H and the residents as her accent was difficult to understand, which frustrated the residents, and then she would get frustrated with them. She did not think CNA H was trying to be mean or rough with the residents. 9. Interview on 12/11/25 at 11:30 a.m. with travel CNA H in the day room revealed: *Resident 7 would tell her how she wanted things done for her. *She transferred resident 7 using a mechanical lift with two staff members.*Resident 7 was calm and cooperative when transferring her. *Sometimes, resident 7 would not want to get out of bed, so she would try again at a later time. *Sometimes, resident 7 would scream at her and another CNA when they helped her with her hygiene needs, and they would explain to her why they needed to help her with those care needs. If that did not calm the resident down, then she would leave the resident's room, give her time, and reapproach her later.*She would notify the nurse if the resident refused care and receive further direction from the nurse.*She was not aware of any staff member being rough with resident 7. *She has not accidently hit resident 7's head on the wall when repositioning her in bed. *She took care of resident 7 often. 10. Interview with administrator A and DON B on 12/11/25 at 11:52 a.m. revealed:*They were not aware of resident 7's concern with a male nurse who picked her up and set her down roughly without using the mechanical lift, or her concern regarding travel CAN H being rough with her. *They were not aware that LPN D had to remove CNA H from a resident's room after she became frustrated with that resident.*Since they were not made aware of the complaints, they would assume LPN D, SW C, and MDS coordinator/RN G resolved those issues with the resident and staff members. *They verified that if the resident's care plan was not followed, it could be considered neglect. *They expected LPN D to assess resident 7 right away(after CNA I reported the concerns with a red spot and staff being rough, instead of doing it later on that day.*They expected investigations regarding resident complaints to be documented in the residents' EMR, and if it was not documented, there was no supportive evidence that an investigation was initiated. *As far as they were aware, an investigation had not been done related to the staff members being rough. *They were responsible for completing the investigations. *They expected staff members to report complaints to them so they could determine if the event needed to be reported to the SD DOH. *They expected SW C and MDS coordinator/RN G to notify them of residents' complaints so they could determine if they needed to be reported to the SD DOH. *DON B did not agree with MDS coordinator/RN G's statement that nothing could be done if no one was named in the complaint and stated complaints would still need to be investigated, and education completed with the staff. *Their process for potential resident abuse or neglect reports from staff would be to not allow that staff member to work with that resident until an investigation was completed related to the event. *CNA H was working in the nursing home (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	currently, so they planned to suspend CNA H from working, interview her, investigate the complaint, and report it to the SD DOH. *Administrator A expected reportable events to be reported to the state immediately and investigated, and the staff member not to work with that resident until the investigation was completed. * Administrator A was the grievance officer, not SW C. 11. Review of the provider's January 2023 Grievance Process policy revealed:* The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC [long term care] facility stay.* The resident has the right to, and the facility will make prompt efforts by the facility to resolve grievances.* The facility has established a grievance policy to ensure the prompt resolution of all grievances regarding the resident's rights.* The grievance official is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility;.and coordinating with state and federal agencies as necessary in light of specific allegations. * As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated.* Consistent with 483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider, and as required by State law. 12. Review of the provider's 10/19/2022 Vulnerable Adult policy revealed:*.[the provider] supports Zero Tolerance for resident abuse, neglect, mistreatment, and/or misappropriation of property.*In compliance with South Dakota regulations and the CMS [Centers for Medicare and Medicaid Services] and NF/SNF [nursing facility/skilled nursing facility] Requirements of Participation (2019).[the provider] has instituted the following policy and procedure on reporting of maltreatment of vulnerable adults. These regulations are intended to protect adults who are dependent upon others for their care. The requirements also assist health care providers to maintain a safe environment for their residents by requiring facilities and other mandated reporters to submit reports of suspected maltreatment or unexplained injuries for review and possible investigation. We believe all adult residents living or receiving services in.[the providers] are vulnerable and it is our policy to ensure the resident is free from abuse, neglect, mistreatment, misappropriation of resident property and exploitation.injuries of unknown source sustained by a vulnerable adult that is not reasonably explained immediately (as soon as possible).[The provider] will report any maltreatment of a vulnerable adult.*Mandated reporters employed by .[the provider] or providing services in our facility shall report abuse, neglect, mistreatment,.and injuries of unknown sources sustained by a vulnerable adult that is not reasonably explained immediately (as soon as possible) after the discovery of the incident.a) Identify Maltreatment: Compare the incident or event to the definitions of Accident, Abuse, Neglect,.and injuries of unknown source.b) Recognize Exception.c) Report: Review the Reporting procedures to find out where, how and when to report internally and externally.*Definitions.f) Maltreatment/Mistreatment 1) Mistreatment means inappropriate treatment or exploitation of a resident.g) Neglect 1) Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. h) Abuse (Abuse must be reported) 1) Abuse is the willful infliction of injury. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. ii) Conduct which produces or could reasonably be expected to produce pain or injury or emotional distress. Such conduct must not result from either (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and policy review, the provider failed to account for the supply of the controlled medication (medication at risk for abuse and addiction), tramadol (controlled pain medication), according to the provider's policy for one of one resident (33):Findings include:1. Observation and interview on 12/11/25 at 8:34 a.m. with certified medication aide (CMA) F morning medication pass revealed:*Resident 33's medication card for her scheduled (given at a set time) dose of tramadol was empty. *The tramadol medication card being used for resident 33's scheduled tramadol dose was different from what she was used to seeing.*Resident 33's tramadol frequency of administration had changed, so they were using up those medication cards before getting new ones.*She was to administer resident 33's scheduled tramadol doses according to the dates labeled on the medication card. If the medication dose was missing, she would tell the nurse. *Resident 33's current tramadol card had dates written in marker by each medication bubble on the medication card that indicated when it was to be administered.*She did not need to sign anything after the scheduled doses of tramadol were given to verify the quantity of the medication count was accurate, but if the medication was given as am as needed (PRN) dose, then the nurse would have to give that dose and sign to verify the quantity of doses remaining in the card. * The night shift nurse and day shift nurse were to count the medications in the controlled medication box for the medication cart she used. At the end of her shift, she would count the medications in that controlled medication box with the day shift nurse to verify the counts of the controlled medications were accurate. 2. Observation and interview on 12/11/25 at 9:57 a.m. with registered nurse (RN) E revealed: *When scheduled tramadol was given to a resident, the dose was to be punched out of the medication card's bubble marked with the current date. Only PRN doses were counted on a controlled medication inventory sheet. The scheduled tramadol cards were not counted. *When looking at the empty tramadol card for resident 33 given to her from medication aide F, she was unsure how many tramadol pills were to be there since there was no controlled medication inventory sheet to indicate how many pills were administered and how many remained available for administration. *Resident 33's tramadol frequency changed on 11/22/25, and then the doses were renumbered on the bubble pack in marker. *There were two scheduled tramadol medication cards that had were partially used with some doses remaining in each of them, in the lock box in the nurses' medication cart for resident 33. She was unsure how many pills were in those cards when they were placed in the drawer and was not sure how many pills were supposed to be left in them that day (11/22/25) because there was no controlled medication inventory sheet for them.-One card had 4 pills left, and the other had 13 pills left. -She then made a controlled medication inventory sheet for the remainder of those pills and did not verify that count with another nurse.*She verified that those tramadol doses were not counted by two nurses at the change of shift because there was no controlled medication inventory sheet for those tramadol doses, but there should have been. 3. Interview on 12/11/25 at 11:45 a.m. with director of nursing (DON) B revealed:*She expected the CMAs and nurses to count the controlled medications and sign the controlled medication inventory sheet to indicate the count was verified when a scheduled and PRN tramadol dose was given. *She expected the tramadol in the nurses' medication cart lock box to have a controlled medication inventory sheet and for them to be counted at the change of shift to verify the count. 4. Review of the provider's 12/3/25 Medication Administration policy revealed:* If medication is a controlled substance, sign narcotic book. 5. Review of the provider's 11/18/25 Controlled Substances policy revealed: *Purposea) To complete a physical inventory of narcotics at each change of shift by two nurses to identify discrepancies and need for reconciliation and accountability. b) To assure controlled drugs are handled, stored, and disposed of properly.c) To assure proper record keeping for controlled drugs. *Procedurec) Narcotic records are reconciled by a physical count of the remaining narcotic supply at the change of each shift by the oncoming and outgoing licensed (continued on next page)

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	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Faulkton Senior Living	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse/designee.f) After the supply is counted and justified, each nurse must record the date and his/her signature verifying that the count is correct.*Receiving Controlled Substancea) When the nurse receives the controlled medication, the nurse will need to fill out the top portion of the controlled drug administration record (information about the medication).c) Each time the medication is given the nurse should fill out the following columns: signature, date, time, amount on hand, amount administered, and amount remaining.