STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A138	A. BUILDING _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICINE WHEEL VILLAGE	24266 AIRPORT ROAD EAGLE BUTTE, SD 57625

(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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/30/24 through 10/3/24. Medicine Wheel Village was found not in compliance with the following requirements: F623, F758, F800, F808, F812, F851, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/30/24 through 10/3/24. Areas surveyed included quality of care, neglect, and elopement as it related to agency staff not following a care plan and facility policy for bathing, resident transfers, and a resident who left the building through an alarmed exit. Medicine Wheel Village was found not in compliance with the following requirement: F609.	F 000		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deb Arbogast
TITLE: Licensed Nursing Facility Administrator
(X6) DATE: 11/14/2024

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 609	Continued From page 1 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incidents (FRI) review, interview, and policy review, the provider failed to provide timely and thorough notification to SD DOH for two of two sample residents (2 and 6) who required evaluation at the emergency room, after sustaining an injury during a transfer (2), and after an unwitnessed fall (6). Findings include: 1. Review of the SD DOH FRI submitted on 3/01/24 at 9:30 p.m. revealed: *On 2/28/24 at 10:00 a.m. resident 2 reported she had "heard a pop" while staff transferred her from the toilet to her wheelchair. *She "stated that her right knee was hurting." *"No swelling or open sores noted to her R [right] knee. *The final report submitted on 3/4/24 stated: -"Neither staff member heard anything, but they did report it to their nurse ..." -The nurse "noted no redness or swelling at this time." *There was no indication that resident 2 had been sent to the emergency room for evaluation in the	F 609		

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F 609	Continued From page 2 provider's FRI report. *There was no indication that resident 2 sustained a "proximal right tibial fracture." *The assessment of pain and swelling did not match the progress notes (PN) in the residents' electronic medical record (EMR). Review of resident 2's EMR revealed: *On 2/28/24 at 10:00 a.m. there was no nurse progress note (PN) that indicated resident 2 had reported she had "heard a pop" while being transferred from the toilet to her wheelchair. *On 2/28/24 at 11:25 p.m. a PN indicated "[Resident 2] Can't sleep. Right knee still hurts." -This was the first PN after the incident that mentioned her right knee. *On 2/28/24 at 11:29 p.m. a PN indicated "Right knee swollen and was elevated on a pillow from day shift. Muscle rub applied to both knees. This writer tried to elevate HOB [head of bed] to give resident her meds. Resident cried out in pain with tears noted. Resident was reassured that knee is just stiff and joint inflammation is what's going on here. Resident was reminded that she hasn't walked for awhile. Resident also received ice pack to right knee." *On 2/28/24 at 11:59 p.m. a PN indicated "CNA [certified nursing assistant] stated that resident also cries out in pain when turning over to have brief [incontinence product] changed." *On 2/29/24 at 4:07 p.m. a PN indicated "This writer was not able to measure wound, C/O [complains of] knee pain and wasn't able to have leg moved, [telehealth provider] was contacted in reguards to knee pain." *On 3/1/24 at 9:34 a.m. a PN indicated "knee pain rated a consistent 8. Pts [patient's] right knee is swollen to about double the size of her other knee, and it is discolored."	F 609	All residents have the potential to be affected including resident 2 and 6 and no other residents affected. Education with RN/LPN department completed on 10/23/2024 to include in Progress Notes with assessment of Clinical condition by RN/LPN on duty with Pain Management evaluated. Weekly Audits times 4 by DON and report Monthly thereafter and report to QAPI. Policy Reviewed with DON, Governing Board Chairman and Medical Director on 10/23/2024. 10/25/2024 DA 10/29/2024 DA 10/30/2024 DA	11/2/24

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F 609	Continued From page 3 -This information was omitted from the SD DOH FRI initial and final reports. *On 3/1/24 at 10:04 a.m. a PN indicated resident 2 had been transferred to the emergency room for evaluation of her right knee pain. -This information was omitted from the SD DOH FRI final report that was submitted on 3/4/24. *On 3/1/24 at 5:05 p.m. a PN indicated "Pt was in the hospital today." *On 3/1/24 at 6:03 p.m. a telehealth provider note indicated "Phone call to facility to speak with nurse. Fx [fracture] of tibia on the right side. She is back in LTC [long-term care] facility." *On 3/1/24 at 7:39 p.m. a PN indicated "f/u [follow up] from [telehealth]. Gave them report of what happened at [hospital] with the Tibia break." -This information was omitted from the SD DOH FRI final report submitted on 3/4/24. *There was no PN that indicated the time that resident 2 returned to the facility. 2. Interview on 10/1/24 at 9:15 a.m. with resident 6 revealed she: *Had fallen "about a month ago." *Stated she "went for a scan but nothing was broken." *Reported she still had "some pain." Review of the SD DOH FRI submitted on 9/16/24 at 2:15 p.m. revealed: *On 9/14/24 at 3:30 p.m. resident 6 was found "sitting on the floor on her bottom with her feet stretched out in front of her." *"Pain was a 2 on pain scale 0-10." *Resident 2 had stated, "The invisible man pushed me down." *A telehealth visit had been completed. *The final report due 9/21/24 had not been	F 609	All residents have the potential to be affected including resident 2 and 6 with no other residents affected. Education with DON and alternate staff who report to SD DOH completed on 10/23/2024 to include in full summary of event with timely reporting to SD DOH with return to facility to be documented. Policy reviewed with DON and Governing Board Chairman. Weekly Audits times 4 by DON and report monthly thereafter and report to QAPI. 10/29/2024 DA 10/30/2024 DA	11/2/24

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F 609	Continued From page 4 submitted to SD DOH. *There was no indication that resident 6 had been sent to the emergency room for evaluation. Review of resident 6's EMR revealed: *On 9/14/24 at 3:30 p.m. there was no nurse PN that indicated resident 6 had fallen. *On 9/14/24 at 5:32 p.m. a PN indicated resident 6 stated, "When are you going to send me to the doctor for mt [my] brittle bones? My bone on my bottom hurts." *On 9/15/24 at 2:45 a.m. a PN indicated "follow up unwitnessed fall from 9/14/24 day shift." *On 9/16/24 at 1:20 p.m. a PN indicated resident 6's family wanted resident 6 to be seen for an x-ray. "She is complaining of left side abdominal pain .... Ambulance here at 12:45 to transport resident to the ER [emergency room]." -This information was omitted from the SD DOH FRI initial report that was submitted on 9/16/24 at 2:15 p.m. Interview on 10/2/24 at 12:12 p.m. with director of nursing (DON) B revealed: *She had not reported resident 2's transfer to the emergency room or injury because: -"We didn't have the information at that time." -"[The resident's primary care physician] didn't think it was a fracture." *She was aware of the SD DOH FRI reporting guidelines. *She had fallen behind in reporting incidents to SD DOH. *She confirmed that the initial report for resident 2 had not been completed on time. *She had not reported resident 6's transfer to the emergency room or injury because: -"Her family wanted her to be seen." -"She always wants to go to the emergency room.	F 609	All residents have the potential to be affected including resident 2 and 6 with no other residents affected. Education with DON and alternate staff who report to SD DOH completed on 10/23/2024 to include in full summary of event with timely reporting to SD DOH. Documentation in Progress Notes education completed on 10/23/2024 by Administrator for RN/LPN department. Policy reviewed with DON, Governing Board Member, and Medical Director on 10/23/2024. Weekly Audits times 4 by DON and report monthly thereafter and report to QAPI. 10/29/2024 DA 10/30/2024 DA	11/2/24

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F 609	Continued From page 5 She was fine." *She confirmed that the final report for resident 6 had not been completed on time. Review of the provider's 10/2/24 Reporting of injuries of Unknown Source and Reasonable Suspicion of a crime education packet revealed: *"Review with all IDT [interdisciplinary team] team members and those designated to report to Department of Health Complaint office." *"Copy of reporting guidelines given to each team member on this date." *"IMMEDIATELY notify the Administrator of the Event, the 2 HOUR clock starts." *"REPORT the reasonable suspicion not later than 2 HOURS after forming the suspicion." "REPORT to: SD DOH COMPLAINT Coordinator ..." *"CONDUCT a thorough internal investigation and Send in findings report within 5 working days." *DON B had signed that she was provided the above information.	F 609	All Residents have the potential to be affected including resident 2 and 6 with no other residents affected. Reeducation with IDT including DON on 10/23/2024 on timely reporting of all reportable events on 10/23/2024. Education also completed at All Staff Meeting on 10/23/2024 for all reportable events in a timely manner per regulations. Weekly Audits for reporting and summary statement for final submission weekly times 4 and monthly thereafter by Administrator and reported to QAPI. Policy Reviewed with DON, Governing Board Chairman and Medical Director on 10/23/2024. 10/29/2024 DA 10/30/2024 DA	11/2/24
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 623		

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F 623	Continued From page 6 accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which	F 623		

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F 623	Continued From page 7 receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as	F 623		

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F 623	Continued From page 8 well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the provider failed to provide a copy of the transfer notice to the Office of the State Long-Term Care Ombudsman for one of one sampled resident (13) reviewed for facility-initiated transfer to the hospital. Findings include: 1. Interview on 9/30/24 at 5:10 p.m. with resident 13 revealed she had gone to the hospital recently, but did not remember why., 2. Review of resident 13's electronic medical record (EMR) revealed: *She was transferred to the hospital on 1/29/24. -Her power of attorney (POA) was notified of her transfer. -There was no documentation the bed hold information was given to the resident or her POA. *She was transferred to the hospital on 9/11/24. -Her POA was notified. -There was no documentation the bed hold information was given to the resident or her POA. 3. Interview with the facility's local ombudsman on 10/3/24 at 8:19 a.m. and again at 11:02 a.m. regarding resident 13's transfers to the hospital revealed: *She stated that she had not received notifications for either of resident 13's hospital transfers above. *She had spoken with social services designee (SSD) C and social services employee D in May 2024 "about the regulation and did share a	F 623	All residents have the potential including resident 13 to be affected. Education completed on 10/23/2024 with IDT for Bed Hold and submission of required reporting for all transfers, discharge completed by Administrator. Weekly Audits times 4 and monthly thereafter for reporting to Ombudsman for all transfers, discharges using the appropriate online submission forms. Medicine Wheel Village Policy and Procedure reviewed and revised with IDT, DON, Governing Board Chairman and Medical Director on 10/23/2024. 10/25/2024 DA 10/30/2024 DA	11/2/24

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F 623	Continued From page 9 document with them at that time as well." 4. Interview on 10/3/24 at 9:11 a.m. with SSD C and social services employee D revealed: *The social services department was responsible for notifications to the ombudsman. -An email was often sent, however, "sometimes we just call her." *They were not aware that they had to report every hospital transfer to the ombudsman. -They completed notifications to the ombudsman on day 5 if the resident was discharged. *No documentation was provided to verify the ombudsman was notified of resident 13's hospital transfers. 5. Review of the document shared with the provider by the Ombudsman revealed: *"Notice before transfer. Before a facility transfers or discharges a resident, the facility must - (i) Notify the resident and the resident representative(s) of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. That facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman."	F 623	All residents have the potential including resident 13 to be affected. Education completed on 10/23/2024 with IDT for Bed Hold and submission of required reporting for all transfers, discharge completed by Administrator. Weekly Audits times 4 and monthly thereafter for reporting to Ombudsman for all transfers, discharges using the appropriate online submission forms. Medicine Wheel Village Policy and Procedure reviewed and revised with IDT, DON, Governing Board Chairman, and Medical Director on 10/23/2024. 10/25/2024 DA 10/30/2024 DA	11/2/24
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		

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F 758	Continued From page 10 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review the provider failed to ensure one of one sampled resident (1) had her as needed (PRN) lorazepam (antianxiety medication) order renewed for continued use beyond 14 days. Findings include: Review of resident 1's electronic medical record (EMR) revealed: *A physician's order on 8/1/24 for lorazepam 0.5 milligrams (mg) orally to be given every four hours as needed for increased anxiety and tooth pain. *Her revised care plan dated 8/6/24 indicated she used antidepressant/antianxiety medication related to depression and anxiety. *A pharmacist recommendation sheet for resident 1 dated 8/31/24 revealed: -PRN orders for psychotropic drugs are limited to 14 days. -Except if the attending or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. -He or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. -It was signed by director of nursing (DON B) and the consultant pharmacist. -The physician's response, had an X marked on the following area: --I would like to specify a duration of this PRN psychotropic as indefinitely and will document the rationale below. --"Patient needs meds when has stressful event." --The physician's signature was dated 9/30/24. --DON B's signature was dated 10/2/24. *From 8/15/24 through 9/30/24 PRN lorazepam	F 758		

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	43A138	A. BUILDING _____ B. WING _____	C 10/03/2024

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F 758	Continued From page 12 was administered 21 times. Interview on 10/2/24 at 3:30 p.m. with DON B and restorative licensed practical nurse (LPN) H regarding resident 1's PRN lorazepam revealed: *They knew PRN lorazepam orders had to be renewed by the physician every 14 days for continued use. *They were not aware the order had not been renewed. *They agreed the lorazepam order was not current. Review of the provider's July 2022 Psychotropic Medication Use policy revealed: *"11. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications." *"12. Psychotropic medications are not prescribed on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. (1) For psychotropic that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration of the PRN order. (2) For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication."	F 758	All residents have the potential to be affected including resident 1 with no other residents affected. Education completed to IDT, DON, and RN/LPN department for PRN Psychotropic usage on 10/23/2024 by Administrator. Weekly Audits by Administrator times 4 and monthly thereafter for PRN Psychotropic usage and report to QAPI. Policy reviewed on 10/23/2024 with DON, Governing Board Chairman and Medical Director. 10/25/2024 DA 10/30/2024 DA	11/2/24
F 800 SS=F	Provided Diet Meets Needs of Each Resident	F 800		

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F 800	Continued From page 13 CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to serve a well-balanced diet that: A. Considered the food preferences for 3 of 3 sampled residents (6, 13, and 16). B. Contained dietician-approved nutritional equivalent food substitutions for 21 of 21 sampled residents (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21) for one of one observed meal service. Findings include: 1. Observation and interview on 10/1/24 at 9:09 a.m. with resident 6 revealed: *She stated, "You get what you get," when asked what she ordered for breakfast. *She had not received a menu of meals for the day. *She had not selected or been asked what she wanted to eat that day. *Menus had been posted in the hallway near the dining room, but it was not always accurate. *The residents had been quarantined in their rooms due to a COVID-19 outbreak and had not been able to check that menu. *She stated, "If you refuse [the meal provided], you get soup." *She had requested softer foods because she did not wear dentures. -She stated, "This fruit [melon and grapes] is	F 800		11/2/24

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F 800	Continued From page 14 hard." Review of resident 6's electronic medical record revealed: *A 11/3/22 physician's order for "Diet Regular diet, Mechanical Soft texture." *She had a Brief Interview for Mental Status (BIMS) score of 14 which indicated she was cognitively intact. Observation and interview on 10/1/24 at 10:34 a.m. with resident 13 revealed: *There were uneaten pancakes with syrup and sausage on her plate that had been covered. *She had not liked what was served that day and wanted another choice. -She had "wanted malt-o-meal." *She stated, "You get what is provided." *If she had been given a choice she would have ordered something different. Review of resident 13's electronic medical record revealed: *A 4/13/2 physician's order for a "Consistent Carbohydrate diet, Regular texture, Regular consistency." *She had a Brief Interview for Mental Status (BIMS) score of 12 which indicated she was moderately cognitively impaired. *Her diagnosis included "Type 2 Diabetes Mellitus with Hyperglycemia." *Her care plan indicated: -"Poor appetite." -"Refuses to eat at times." -"Monitor nutritional status." -"Serve diet as ordered." Interview on 10/1/24 at 11:07 a.m. with resident 16 revealed she stated:	F 800		

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F 800	Continued From page 15 *"I don't care for a lot of things they have. *"If I don't like what they bring me I can have soup." *"They put it [the menu] up on the board." *"I am tired of hamburgers." *"You get what they bring." Review of resident 16's electronic medical record revealed: *A 12/1/23 physician's order for "Diet Consistent Carb [carbohydrate], NAS [no added salt] diet, Regular texture, Regular consistency." *She had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. *Her diagnosis included Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease" and "Essential (Primary) Hypertension." Interview on 10/1/24 at 8:00 a.m. with dietary manager (DM) E regarding an alternative menu revealed they did not have an alternative menu, but if the resident did not like what was served they would be able to have soup or hot/cold cereal. 2. Observation on 9/30/24 at 3:45 p.m. of unidentified CNA during the initial tour in the kitchen revealed: *CNA was making ham salad sandwiches for the residents' evening meal. *CNA was not using a measuring scoop to correctly portion the amount of salad put on each sandwich. *The bread used for the sandwich was a "slider" bun, approximately one-half the side of a standard hamburger bun. Observation on 10/2/24 at 4:13 p.m. of cook J	F 800		

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F 800	Continued From page 16 revealed: *While preparing the cucumbers with ranch portions, she was not using a measuring utensil to measure the portion for each meal tray. *While preparing the three bean salad portions, she was not using a measuring utensil to measure the portion for each meal tray. Interview on 10/1/24 at 8:35 a.m. with dietary manager E revealed: *The CNA that was making the ham salad sandwiches was not part of the regular kitchen staff. -The CNA was helping due to short staffing. *She stated that she had trained the CNA to use the one-half cup scoop to portion the ham salad, but the thought the CNA must have been nervous because the surveyors were watching her. *When asked what options the resident would have if they did not like what was being served, she stated that the resident could have soup or cereal. There was no alternate meal prepared. Interview on 10/1/24 at 9:35 a.m. with resident 14 revealed: *This was the first time he had lived in a nursing home, and he had been there for a few months. *He stated that the food was good, but he did not get enough. *When asked if he was able to get more food if he asked for it, he stated, "Sometimes". *When asked if he was offered an alternate option if he did not like what was being served, he stated "No." *When asked if the staff brought him snacks between meals, he stated "Sometimes." *When asked how often staff brought him snacks, he stated "Maybe two to three times a day."	F 800	Potential for all residents to be affected if appropriate measuring utensils are not used. Education to all staff on following menus and using appropriate measuring utensils during all staff meeting on 10/23/2024 by Administrator. Dietary Manager will audit use of appropriate measuring utensils weekly times 4 and monthly thereafter. Dietary Manager will report to QAPI. 10/25/2024 DA 10/30/2024 DA	11/2/24

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F 800	Continued From page 17 Interview on 10/2/24 at 10:52 a.m. with registered dietician M revealed: *She was a contracted employee, and her role was to approve food menus. *She did not visit the facility. *She approved the menus the facility used, they were provided to the facility by "US Foods", which was the facility's food distributor. *She stated that the facility should have been notifying her when substitutions were made, but that was not happening. *She stated the diet extensions should be used, but that was difficult when staff were not making food from the menu. Interview on 10/3/24 at 9:40 a.m. with administrator A revealed: *The kitchen had recently had a difficult time with adequate staff due to COVID-19 and staff turnover. *She acknowledged that substitutions were made regularly, and this was due to food availability and resident preference. *She stated that substitutions were allowed to be done but needed to be documented as to why they were being done and the dietician needed to be made aware of the substitution menus. *It was her expectation that serving sizes would be consistent by using appropriate serving utensils. *She stated that the facility planned to work with a new company that would be able to accommodate the resident's dietary needs as well as cultural food preferences. Review of the provider's April 2019 Frequency of Meals policy revealed: *Policy Statement: "Each resident shall receive at least three (3) meals daily, at times comparable	F 800	All residents have the potential to be affected including resident 6,13,14 and 16 and will be offered meal substitute and snacks daily per individual preference. Education for menu, menu substitutions, snacks and extensions completed on 10/23/2024 at All Staff in service by Administrator. Dietary Manager completed reeducation on 10/23/2024 with dietary staff. Dietary Manager will submit all menu changes to RD weekly. Audits will be completed by Dietary Manager weekly times 4 and monthly thereafter and reporting to QAPI. Policy review with DON, Dietary, Governing Board Chairman, and Medical Director on 10/23/2024. 10/25/2024 DA 10/30/2024 DA	11/2/24

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F 800	Continued From page 18 to typical mealtimes in the community, or in accordance with resident needs, preferences, requests and the plan of care."	F 800		
F 808 SS=E	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to provide the therapeutic diet prescribed by a physician for 16 of 21 (2,3,4,5,7,8,9,11,12,13,14,16,17,18,19,21) residents. Findings include: 1. Observation on 9/30/24 at 3:40 p.m. revealed: * Spaghetti had been served for the lunch meal instead of the approved scheduled menu item of Asian barbecue turkey. *There was no indication on the kitchen menu that the substitution was approved by the dietician or documentation that the substitution was made. *All residents received the same meal with no differentiation between their individually prescribed diets (regular, heart healthy, renal, consistent carbohydrate, and no added salt diets). 2. Observation on 9/30/24 at 4:45 p.m. revealed:	F 808		

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F 808	Continued From page 19 *A ham salad sandwich on a slider-sized roll was served for the evening meal instead of spinach and cheese quiche that was listed on the approved scheduled menu. *There was no indication on the kitchen menu that the substitution was approved by the dietician or documented that the substitution was made. *All residents received the same meal with no differentiation between prescribed diets. 3. Observation on 10/1/24 at 11:40 a.m. revealed: *Taco burgers and chicken noodle soup with potato wedges were served for lunch instead of the approved scheduled menu item of ham steak with honey mustard sauce, twice baked sweet potato, sauteed Brussel sprouts, dinner roll/margarine, and pineapple with toasted coconut. *There was no indication on the kitchen menu that the substitution was approved by the dietician or documentation that the substitution was made. *All residents received the same meal with no differentiation between their prescribed diets. 4. Interview on 10/1/24 at 8:35 with dietary manager E revealed: *She stated that the kitchen made substitutions due to the lack of availability of the menu items. *She stated that she did not know what some of the items on the menu were. *She stated that she had not been documenting when and what substitutions had been made. *She stated that she made taco burgers every Tuesday because the residents liked them. *When asked if the substitutions had been approved by the dietician, she stated that they had not been. *When asked if an alternate menu option was available, she stated that if a resident doesn't like	F 808		

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F 808	Continued From page 20 what is being served, they can have soup or cereal. 5. Interview by phone on 10/2/24 at 10:52 a.m. with registered dietician M revealed: *Her involvement with the facility is to review and approve the food menus for the facility. *She stated, "They should be notifying me of the substitutions, but they are not." *She stated that she had previously voiced concerns about kitchen staff not following the menu. *She stated that she had previously asked for the menu substitution log but did not receive accurate substitutions menus. 6. Interview on 10/3/24 at 8:40 am with administrator A revealed: *She was aware that ordered menus were not being followed. *She stated there were challenges to following the menu due to residents not wanting to follow their prescribed diet. *She stated that there were times when elderly protection would complain on behalf of the resident and that was part of the reason that diets were not being followed. *There was no written documentation that residents refused to follow their prescribed diets. *She agreed that diets ordered by a physician should be followed but stated many of the residents would not follow their prescribed diet. 7. Record review on 10/2/24 of the provider's dietary orders revealed: *Residents 2,3,4,5,7,8,9,11,12,13,14,16,17,18,19, and 21 did not have specific dietary orders addressed. -Eight residents were ordered a consistent	F 808	All residents have the potential to be affected. All residents will be offered meal substitute per preference daily. Education for Menu, menu substitutions, snacks, and extensions completed on 10/23/2024 at All Staff in service by Administrator. Dietary Manager completed reeducation on 10/23/2024 with Dietary Staff. Dietary Manager will submit all menu changes to RD weekly. Audits will be completed by Dietary Manager weekly times 4 and monthly thereafter and reporting to QAPI. Policy review with DON, Dietary, Governing Board Chairman and Medical Director on 10/23/2024. 10/25/2024 DA 10/30DA	11/2/24

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F 808	Continued From page 21 carbohydrate diet. -Five residents were ordered a heart healthy diet. -Six residents were ordered a no added salt diet. -Two residents were ordered a renal diet. 8. Review of the provider's April 2019 Frequency of Meals policy revealed: *Policy Statement: "Each resident shall receive at least three (3) meals daily, at times comparable to typical mealtimes in the community, or in accordance with resident needs, preferences, requests and the plan of care." 9. Policy review of the provider's October 2017 Foods Brought by Family/Visitor policy revealed: *Policy Interpretation and Implementation, line 13, "When meals or snacks are provided by family/visitors, the nurse will inform the dietician of these substitutions."	F 808		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		

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F 812	Continued From page 22 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure that one of one sampled resident (1) received a food prepared to correct temperature. Findings include: 1. Observation on 9/30/24 at 3:40 p.m. of the kitchen warming cabinet revealed: *The food warming cabinet thermometer was not functioning. *The dial for temperature control was set at 6.5 on 0-10 range. 2. Observation and interview on 10/1/24 at 12:00 with dietary manager E revealed: *She had pureed and placed resident 1's noon meal in the warming cabinet. *She stated the food had been pureed with warm broth. *The dial on the food warming cabinet was set at 5.5, the dial ranged 0 to 10. *She said that before the warming cabinet thermometer stopped working, this was the normal setting to keep food warmed to the appropriate temperature. *The taco meat used for the pureed meal was documented to be 176 degrees Fahrenheit (F)before being placed in the food warming cabinet. *The temperature of the pureed food was 113.7 degrees Fahrenheit. *She stated she would not recheck the temperature or reheat the pureed food before serving it to the resident.	F 812		

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F 812	Continued From page 23 3. Observation and interview on 10/2/24 at 4:33 p.m. with cook J revealed: *Hot chicken broth from the steamer was used to puree resident 1's. *After being pureed, the steamed vegetables were 113.3 degrees Fahrenheit. *After being pureed, the boneless pork rib was 107.9 degrees Fahrenheit. *After being pureed, the roasted potatoes were 107.9 degrees Fahrenheit. *Cook J stated that she would place pureed foods back in the warming cabinet until serving and she would not further heat the food. 4. Interview on 10/1/24 at 8:35 a.m. with dietary manager E revealed: *The food warming cabinet thermometer has been broken for two to three months. *The maintenance department is aware and has ordered a new food warming cabinet. *There was no internal thermometer placed in the warming cabinet to ensure safe food temperatures. 5. Interview on 10/2/24 at 8:40 a.m. with maintenance director F revealed: *He stated that he was made aware the food warming cabinet thermometer by dietary manager E on 5/20/24. *He stated there was a new food warming cabinet ordered on 10/1/24. 6. Interview on 10/3/24 at 9:40 with administrator A revealed: *She stated that she was recently made aware that the food warming cabinet was not functioning properly. *She stated that she told maintenance director F	F 812		

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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
F 812	Continued From page 24 to order a new food warming cabinet the previous week. *She expected that the facility's food preparation and service policy would be followed. 7. Review of the facility's food temperature log revealed: *All cooked food's internal temperatures had been documented after cooking, before being placed in the food warming cabinet. *There was no record of food temperatures being documented after pureeing, before being served to the resident. 8. Policy review on 10/3/24 of the facilities food preparation and service policy revealed: *"The "danger zone" for food temperatures is between 41 degrees Fahrenheit and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness." *"Mechanically altered hot foods prepared for a modified consistency diet remain above 135 degrees Fahrenheit during preparation or they are reheated to 165 degrees Fahrenheit for at least 15 seconds."	F 812	All residents have the potential to be affected. New food warming cabinet has been installed. Food Temps will be completed for temp of food in cabinet, after pureed and during serving. Dietary Manager completed education to dietary staff on 10/23/2024. Dietary Manager will complete audits weekly times 4 and monthly thereafter and report to QAPI. 10/25/2024 DA 10/30/2024 DA	11/2/24
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by	F 851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A138	A. BUILDING _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICINE WHEEL VILLAGE	24266 AIRPORT ROAD EAGLE BUTTE, SD 57625

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F 851	Continued From page 25 CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.	F 851		

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F 851	Continued From page 26 §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on Certification and Survey Provider Enhanced Reports (CASPER) reporting data review, interview, and policy review, the provider failed to ensure their Payroll Based Journal (PBJ), (information of the provider's daily staffing hours for the appropriate care of the residents) had been complete and the data had been submitted to the Center for Medicare and Medicaid Services (CMS) for one of four quarters (Quarter 1, 2024). Findings include: 1. Review of the provider's CASPER reporting data revealed no PBJ data had been submitted for the time period of October 1, 2023, through December 31, 2023. Interview on 10/1/24 at 3:47 p.m. with administrator A regarding the submission of PBJ data to CMS revealed: *She was aware the data had to have been submitted. *She knew there were deadlines to submit the data. *They had a vendor who kept track of payroll and PBJ data. *The vendor had missed the deadline for submitting the Quarter 1, 2024 PBJ data to CMS.	F 851		

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F 851	Continued From page 27 Interview on 10/3/24 at 9:00 a.m. with administrator A and outsourced chief financial officer (CFO) L regarding the submission of PBJ data to CMS revealed: *Outsourced CFO L was responsible for ensuring the PBJ data was submitted to CMS. *His office would get the data from the provider and ensure it was submitted by the deadline. *A staff member from outsourced CFO L's office missed the deadline for submitting the data by one day. *It was both their expectations that the data would be submitted to CMS before the deadline each quarter. Review of the providers revised 1/4/23 Payroll Based Journal policy revealed, "It is the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS."	F 851	Future Submissions for the outsourced PBJ reporting will be reviewed by the CFO 14 days prior to the reporting time period. The CFO will review all Casper Reports to audit coverage and look for any reporting errors. CFO will audit monthly and report findings to QAPI. 10/25/2024 DA	11/2/24
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		

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F 880	Continued From page 28 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 29 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review the provider failed to ensure two of two sampled residents (2 and 18) with open wounds had been placed on enhanced barrier precautions (EBP). Findings include: 1. Observation on 10/1/24 at 8:00 a.m. of two unidentified staff entering resident 2's room with the Hoyer lift (a mechanical lift with a body sling used for transfers) revealed neither staff member had worn a gown prior to entering the room. Observation and interview on 10/2/24 at 10:03 a.m. with resident 2 revealed: *The door to her room was open and held an over-the-door rack that contained gowns and gloves. *There was a sign indicating the need for EBP on that side of the door. *That sign and those supplies had not been visible with the door open and were located outside that resident's room when that door was closed.	F 880		

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F 880	Continued From page 30 *Resident 2 stated that the staff had not worn a gown or gloves when they transferred her with the mechanical lift or the gait belt. Interview on 10/2/24 at 10:09 a.m. with certified nursing assistant (CNA) K revealed: *Resident 2 required the use of the Hoyer lift and two CNAs for all transfers. *Resident 2 sometimes refused the Hoyer lift and could be transferred with a gait belt and two CNAs *She had not worn a gown when she completed any transfers with resident 2. Review of resident 2's electronic medical record (EMR) revealed "Dressing to right lower extremity .... related to non-pressure chronic ulcer of unspecified part of right leg ..." 2. Observation and interview on 9/30/24 at 4:94 p.m. with resident 18 revealed: *There had not been any signage on the door or in the room that indicated EBP. *There had not been any gowns in the room or near the door. *She wore heel protector boots on both feet and stated she had an open wound on her left foot. *She stated that the staff did not wear a gown or gloves when they transferred her, but that they wore gloves when they had changed the bandage on her foot. Observation on 10/1/24 at 4:20 p.m. of licensed practical nurse (LPN) H, CNA K, with resident 18 revealed: *LPN H and CNA K transferred resident 18 from her bed to the wheelchair. -LPN H and CNA K had not worn a gown or gloves.	F 880		

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F 880	Continued From page 31 Observation on 10/1/24 at 4:40 p.m. of licensed practical nurse (LPN) H, certified nursing assistant (CNA) K, with resident 18 revealed: *CNA K assisted resident 18 with a whirlpool bath. -CNA K wore gloves but did not wear a gown. *LPN H applied a bandage to resident 18's left foot. -LPN H wore gloves but did not wear a gown. Interview on 10/01/24 at 5:31 p.m. with LPN H revealed she: *Did not know the facility policy on EBP. *Confirmed she had not worn a gown when she transferred or completed wound care for resident 18. Review of resident 18's electronic medical record (EMR) revealed a dressing change was ordered to be completed "every day shift for Ischemic injury to right great toe." Interview on 10/2/24 at 11:37 a.m. with LPN H revealed she: *Received training on EBP on 4/2/24 from administrator (Admin) A. -Had been told that only residents with a multi-drug resistant organism (MDRO) required EBP. -Hnad not been educated that all residents with open wounds require EBP *Stated, "I did not know." *Stated resident 2 required EBP only when they changed her dressings on her leg due to the presence of an MDRO. Interview on 10/2/24 at 4:36 p.m. with infection control registered nurse (ICRN) G revealed:	F 880		

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F 880	Continued From page 32 *Residents with wounds would have only had EBP in place if they had an MDRO or the wound was "seeping" and "could not be contained." *She expected the nurse to have worn a gown to complete a dressing change for resident 2 but not for resident 18. *She had not expected staff to wear gowns with residents 2 or 18 when completing transfers or bathing. 3. Review of the provider's 8/12/24 Enhanced Barrier Precautions policy revealed: *"Enhanced barrier precautions" (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. *"An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., Chronic wounds such as pressure ulcers diabetic foot ulcer's unhealed surgical wounds and chronic visa stasis ulcers) and/or indwelling medical devices ..." *"High-contact resident care activities include: a. Dressing, b. Bathing, c. Transferring, ...h. Wound care: any skin opening requiring a dressing."	F 880	All Residents have the potential to be affected including resident 2 and 18. All Staff reeducation completed on 10/23/2024 for EBP Policy and Procedure with All Staff. Administrator reviewed EBP Policy and Procedure with DON, Governing Board Chairman and Medical Director. Audit weekly times 4 and monthly thereafter for following EBP procedure by Infection Control RN and reported to QAPI monthly. 10/25/2024 DA 10/30/2024 DA	11/2/24

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E 000	Initial Comments 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 on 10/1/24. Medicine Wheel Village was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at E004 and E015 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E 000		
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:	E 004		

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

TITLE
Licensed Nursing Facility Administrator

(X6) DATE
10/25/2024

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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E 004	Continued From page 1 * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to update the emergency preparedness plan as a team. Findings include: Record review on 10/1/24 at 4:10 p.m. revealed no documentation the provider's current emergency preparedness plan was reviewed as a team. Interview with the administrator on 10/1/24 at 4:15 p.m. confirmed that finding. She indicated the plan had been updated in September 2024 but had not been reviewed as a team.	E 004	Medicine Wheel Village reviewed the Emergency Plan with Department managers on 9/23/2024 and at All Staff inservice. 9/25/2024 DA	11/2/24

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E 015	Continued From page 2	E 015		
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the	E 015		

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E 015	Continued From page 3 following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to obtain memorandums of understanding for emergency supplies or develop a three-day resident meal plan. Findings include: Record review on 10/1/24 at 4:00 p.m. revealed no documentation for the following: 1. Memorandums of understanding for food, water, medical and pharmaceutical supplies. 2. A three-day emergency menu for residents and staff. Interview with the administrator on 10/1/24 at 4:15 p.m. confirmed that finding.	E 015	Medicine Wheel Village has obtained Memorandums of understanding for water, medical and Pharmaceutical supplies and food with a 7 day Menu plan from US foods. 9/25/2024 DA	11/2/24

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K 000	INITIAL COMMENTS A recertification survey was conducted on 10/1/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Medicine Wheel Village was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K200, K222, and K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 200 SS=D	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to provide operable egress doors as required at one randomly observed exit door location (service wing to the exterior). Findings include: 1. Observation on 10/1/24 at 3:45 p.m. revealed the exterior exit door from the laundry area of the	K 200		

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

TITLE
Licensed Nursing Facility Administrator

(X6) DATE
10/25/2024

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
	43A138	A. BUILDING **01 - MAIN** B. WING	**10/01/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICINE WHEEL VILLAGE	**24266 AIRPORT ROAD** **EAGLE BUTTE, SD 57625**

(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 200	Continued From page 1 service wing was taped off with construction tape. The EXIT sign was still in place and lit. Interview at the time of the observation with the maintenance supervisor confirmed those conditions. He indicated there was construction excavation outside the exit and it was out of service. The EXIT sign needed to be covered to prevent unauthorized egress at that location. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.1, 7.2.1.4.5.1(2)	K 200	Maintenance Director had the E gress door exit sign covered and will not be used as an exit to prevent unauthorized egress at that location on October 3rd, 2024. 10/25/2024 DA	11/2/24
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A138	A. BUILDING **01 - MAIN** B. WING _____	**10/01/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICINE WHEEL VILLAGE	**24266 AIRPORT ROAD** **EAGLE BUTTE, SD 57625**

(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 222	Continued From page 2 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A138	A. BUILDING **01 - MAIN** B. WING _____	**10/01/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICINE WHEEL VILLAGE	**24266 AIRPORT ROAD** **EAGLE BUTTE, SD 57625**

(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 222	Continued From page 3 detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide egress doors as required at two exit door locations (cross-corridor doors to the service wing and door from the service wing to the corridor). Findings include: 1. Observation on 10/1/24 at 3:30 p.m. revealed the cross-corridor exit doors to the service wing was equipped with a magnetic lock that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed that action would initiate an irreversible process to unlock the magnet and release the door. That indicated the magnetically locked doors were functioning as a delayed egress locked door. There was not the required signage mounted on the doors indicating they were delayed egress and how to exit. 2. Observation on 10/1/24 at 3:45 p.m. revealed the single exit door to the corridor from the service wing was equipped with a magnetic lock that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed that action would initiate an irreversible process to unlock the magnet and release the door. That indicated the magnetically locked door was functioning as a delayed egress locked door. There was not the required signage mounted on the door indicating it was delayed egress and how to exit. Interview at the time of the observation with the maintenance director confirmed that condition.	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A138	A. BUILDING **01 - MAIN** B. WING _____	**10/01/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICINE WHEEL VILLAGE	**24266 AIRPORT ROAD EAGLE BUTTE, SD 57625**

(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 222	Continued From page 4 He indicated he would have the correct signage installed as soon as possible. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 222	Maintenance Director had the required signage mounted on the doors on October 3rd, 2024. Weekly for required signage on doors audit times 4 and monthly thereafter and report to QAPI. 9/25/2024 DA	11/2/24
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to maintain the automatic fire sprinkler system as required for two of six zones	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A138	A. BUILDING **01 - MAIN** B. WING _____	**10/01/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICINE WHEEL VILLAGE	**24266 AIRPORT ROAD** **EAGLE BUTTE, SD 57625**

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K 353	Continued From page 5 (System unit #3 Zone 3 Wing D and system unit #4 Zone 6). Findings include: 1. Record review on 10/1/24 at 4:20 p.m. revealed the automatic fire sprinkler system report dated 2/8/23 revealed the following: *The system had not remained fully in service since the prior inspection in 2022 *Not all the fire protection systems were in service without modification since the prior inspection in 2022 *The system had not been free of actuations or alarms since the prior inspection in 2022 *The wet system piping was not protected from temperatures below 40 degrees Fahrenheit *The alarm panel could not be cleared upon leaving There was no documentation indicating the above noted issues had been corrected. Interview with the maintenance manager at the time of the record review confirmed those findings. He indicated the system was in the process of being repaired and updated with a new nitrogen system. He indicated a waiver had been issued to allow the repairs to be completed by February 2, 2025. The deficiency affected 100% of the occupants of those smoke compartments.	K 353	Automatic Fire Sprinkler System upgrade is in progress with Rapid Fire and installation to be completed prior to the February 2nd, 2025 waiver. Weekly progress Audits to be completed by Maintenance Director and reported monthly to QAPI until completion of project. 10/25/2024 DA	11/2/24

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
	68814	A. BUILDING: _____ B. WING _____	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICINE WHEEL VILLAGE	24266 AIRPORT ROAD PO BOX 880 EAGLE BUTTE, SD 57625

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/30/24 though 10/3/24. Medicine Wheel Village was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement 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 9/30/24 through 10/3/24. Medicine Wheel Village was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deb Arbogast

TITLE: Licensed Nursing Facility Administrator

(X6) DATE