STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A138	A. BUILDING B. WING	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 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
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 3/25/26. Areas surveyed included resident neglect related to a certified nursing assistant's (CNA's) failure to provide resident care with toileting after the resident used her call light and requested assistance, as well as moisture-associated skin damage (softening, whitening, or breaking down of skin caused by prolonged exposure to moisture) that a resident developed; and professional standards to ensure the services provided met acceptable standards of clinical practice after a physician ordered nursing staff to borrow a controlled medication from one resident and give it to another. Medicine Wheel Village was found to have past non-compliance at F600 and F658.	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to protect the residents' right to be free from neglect	F0600	"Past Noncompliance - no plan of correction required"	04/10/2026

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 reverse for further 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
Deb Arbogast	Nursing Home Administrator	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 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
F0600 SS = D	Continued from page 1 for two of two sampled residents (1 and 2) by one of one certified nursing assistant (CNA) H who had not provided for the residents' activities of daily living needs. This failure resulted in resident 1 not being assisted with her toileting needs after using the call light and resident 2 developing moisture-associated skin damage to his buttock region. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's submitted SD DOH FRI report revealed that on the night of 1/15/26 through the morning of 1/16/26, licensed practical nurse (LPN) C had difficulty with traveling certified nursing assistant (CNA) H providing care to residents. CNA H was refusing to answer residents' call lights, was on her cell phone multiple times, and neglected to toilet and change the residents' incontinence (involuntary urine or bowel leakage) products. The call light for resident 1 alarmed; CNA H entered resident 1's room, turned off the call light, and exited the room. LPN C noticed that resident 1's call light alarmed shortly after CNA H exited the room, so LPN C responded to the call light and entered resident 1's room to turn it off. Resident 1 told LPN C she needed to use the bathroom and stated that CNA H would not help her. LPN C asked registered nurse (RN) I for help, and together they assisted resident 1 to the toilet, provided her with hygiene care, and assisted the resident to her bed. On the morning of 1/16/26, before the night shift ended, LPN C asked CNA H to assist residents who were awake in getting up and ready for breakfast. LPN C also asked if CNA H had finished her resident rounds (regular scheduled checks a CNA completes to ensure residents are safe, comfortable, and have their basic needs met), and CNA H replied "yes." However, LPN C later found out that CNA H did not assist any residents that morning or finish her resident care rounds. Resident interviews and skin checks were conducted on 1/16/26 by DON B to determine if CNA H's neglect in providing resident care caused any residents' harm. It was found that residents 1 and 2 had not been checked by CNA H during the previous scheduled night shift and	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 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
F0600 SS = D	Continued from page 2 were discovered with heavily saturated incontinent products. Their beds were also saturated with urine. Resident 1 showed no skin issues, but resident 2 had redness and moisture-associated skin damage in the buttock area. No open sores were observed, and his redness and skin damage resolved by 1/20/26. On 1/16/26, administrator A contacted the contract company that CNA H was employed with and informed them of her disregard for resident care and poor performance. The contract company canceled CNA H's contract with the facility, and the facility was instructed to have CNA H leave the premises immediately and have no further contact with CNA H. CNA H returned her facility key and was escorted by maintenance staff F to the front door. She left the facility, and her employee badge was deactivated. 2. Review of resident 1's electronic medical record (EMR) revealed that she was recently re-admitted to the facility on 3/19/26 from a hospitalization stay. Her diagnoses included arthritis (stiffness, pain, and swelling in one or more joints), a history of a hip fracture, a chronic non-pressure ulcer of the right lower leg, a disorder of bone density, and mild dementia. Her 3/15/26 Brief Interview for Mental Status (BIMS) assessment score was 11, which indicated her cognition was moderately impaired. Resident 1's care plan, dated 3/15/22 with a revision on 1/30/26, revealed that she had focus areas for her impaired functional abilities and activities of daily living (ADL), which indicated she had self-care, mobility, and ADL deficits. Resident 1's goals were for her to show no decline in her self-care and mobility deficits, and for the staff to provide total assistance with ADLs through the review date. The interventions included her dependence on staff to provide all assistance with transfers using a Hoyer lift (a mechanical lift and sling used to lift a person's full body). Resident 1 was to be assisted by nursing staff with toileting or using a bedpan and provided with hygiene assistance as needed. Resident 1 was to be turned and repositioned every one to two hours while she was in bed. 3. Review of resident 2's EMR revealed that he was re-admitted to the facility on 8/1/19 from a hospitalization stay. His diagnoses included obesity, arthritis, muscle weakness, encephalopathy (a brain	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 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
F0600 SS = D	Continued from page 3 dysfunction that can result from head trauma, infections, lack of oxygen), a history of traumatic brain injury (a brain injury caused by a forceful bump, blow, or jolt to the head), a left lower leg contracture, and mild dementia. Resident 2's care plan, dated 1/30/19 with a revision on 5/28/24, revealed that he had a focus area for his ADLs, indicating a self-care deficit related to his traumatic brain injury and a left lower leg contracture. Resident 2's interventions included his need for extensive assistance from two staff members to use a sit-to-stand lift (a mechanical lift used to move from a seated to a standing position). Resident 2 was to be assisted by two nursing staff with his toileting schedule and provided with hygiene assistance. Staff were to help resident 2 with his toileting when he woke up in the mornings, before and after his meals, at bedtime, and during nursing rounds at night. 4. Review of CNA H's personnel file showed that she was hired at the nursing home facility on 1/5/26, and her background check was completed, with no issues found. She completed her new hire orientation training. Her training and education revealed that she completed "Reporting Abuse and Neglect," "Abuse, Neglect, and Exploitation," and "Assisting with Elimination" with her contracted travel company on 12/20/25. CNA H also received "Abuse Reporting" and "Resident Abuse" on 1/5/26 at the nursing home facility. 5. Interview on 3/25/26 at 3:15 p.m. with Maintenance staff person F revealed that on the evening of 1/16/26, he was asked by administrator A to escort CNA H off the premises. He stated he found CNA H outside, explained that he was to escort her off the premises, and she questioned him about why that was happening. He said that he explained to CNA H that her contract to work at the facility had been terminated, told her to gather her personal belongings, and informed CNA H that she was to leave. Maintenance staff F then escorted CNA H to her boarding room (a room within a building, often rented or used by employees for sleeping and living quarters). CNA H gathered her personal items, returned her facility key, was escorted to the front entrance, and left the facility. 6. Resident 1 was unable to participate in an interview during the survey as she was hospitalized.	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 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
F0600 SS = D	Continued from page 4 7. Interview on 3/25/26 at 3:00 p.m. with resident 2 in his room revealed that he did not recall having any concerns with staff or their care of him. 8. Interview on 3/25/26 at 4:00 p.m. with administrator A and director of nursing (DON) B revealed that CNA H's neglect, involving her disregard for resident care on 1/16/26, was identified immediately after LPN C reported her concerns to management on 1/16/26. Administrator A stated that interventions were implemented on 1/16/26 to obtain resident interviews and skin assessments to determine if any harm occurred. DON B said that all nursing staff were provided with training and education on 1/21/26 regarding abuse and neglect, incident reporting, and the grievance process. Administrator A and DON B acknowledged that CNA H's failure to provide resident care led to resident 1 not receiving assistance when she asked CNA H to help with her toileting needs after using her call light, and resident 2 developing moisture-associated skin damage to his buttock region. Administrator A stated that it was the facility's responsibility to ensure that nursing staff provided quality care to residents and to initiate disciplinary action with staff if abuse or neglect were found. Administrator A and DON B acknowledged that CNA H was terminated from the facility on 1/16/26 as a result of their investigation into the resident's neglect. They both acknowledged that audits of incident reporting were being conducted and that the results were being presented at monthly quality assurance meetings. 9. Interview on 3/25/26 at 6:30 p.m. with LPN C revealed that on the night of 1/15/26 through the morning of 1/16/26, LPN C had difficulty with traveling certified nursing assistant (CNA) H providing care to residents. CNA H was refusing to answer residents' call lights, was on her cell phone multiple times, and neglected to assist residents to the toilet and change the residents' incontinence (involuntary urine or bowel leakage) products. The call light for resident 1 came on; CNA H answered it, turned it off, and exited resident 1's room. LPN C noticed the light coming right back on and re-entered	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 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
F0600 SS = D	Continued from page 5 resident 1's room to turn it off. The resident told LPN C she needed to use the bathroom and that CNA H would not help her. LPN C and registered nurse (RN) I assisted resident 1 to the toilet, with her hygiene, and assisted her back to her bed. On the morning of 1/16/26, prior to the end of the night shift, LPN C asked CNA H to assist residents who were awake in getting them up and ready to go out for breakfast. LPN C also inquired if CNA H had completed her resident rounds, to which CNA H replied "yes". However, LPN C stated that CNA H did not assist any residents that morning or complete her resident care rounds prior to leaving her night shift. LPN C reported to management her concerns about resident neglect by CNA H, who failed to provide proper care and showed disregard for the residents' well-being on 1/16/26. 10. Review of the provider's Certified Nursing Assistant job description revealed that "The primary purpose of this position is to provide residents with routine daily nursing care and services in accordance with the resident's assessment and care plan and as directed by supervisors." 11. Review of the provider's revised March 2018 Abuse and Neglect policy revealed "Neglect, as 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," and the "Facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect." 12. Review of the provider's revised August 2022 Nurse Aide Qualifications and Training Requirements policy revealed that "Nurse Aides are any individuals providing nursing services to residents in a facility," and "Must possess a sincere desire to serve the ill, aged and infirm." 13. Review of the provider's revised August 2022 Staffing, Sufficient and Competent Nursing policy revealed that "Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including: attaining or maintaining the highest practicable physical, mental and psychosocial	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 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
F0600 SS = D	Continued from page 6 well-being of each resident," and "responding to resident needs." 14. Review of the provider's revised March 2018 Activities of Daily Living (ADL) policy revealed that "Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living." and "residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good grooming and personal hygiene." 15. The provider's implemented actions to ensure that the deficient practice does not reoccur were verified on 3/25/26 after record reviews and interviews revealed that the facility had followed its quality assurance (QAPI) process regarding abuse and neglect. Education was provided to the nursing department on 1/21/26 regarding abuse and neglect, the grievance procedure, incident reporting, supervision of certified nursing assistants, completing ADL resident care, and implementation of the new nurse schedule to accommodate resident needs. Staff were expected to attend; if they were unable to attend in person, a Zoom meeting (a virtual, real-time gathering that allows people to connect via video) was available. An education signature sheet was provided, and signatures were documented. Results of the audits would be reported to the quality assurance committee at their scheduled monthly meetings. Based on the above information, non-compliance at F600 occurred on 1/16/26, and based on the provider's 1/16/26 and additional corrective action plans implemented for the deficient practice confirmed on 3/25/26, the non-compliance is considered past non-compliance.	F0600		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by:	F0658	"Past Noncompliance - no plan of correction required"	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 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
F0658 SS = D	Continued from page 7 Based on a South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interviews, and policy review, the provider failed to ensure services were delivered according to professional standards. One physician (J) gave a verbal order to the director of nursing (DON) B to borrow a controlled medication from one resident (3) and administer it to another resident (4). As a result, licensed practical nurse (LPN E) removed resident 3's controlled medication and administered it to resident 4, which is considered unacceptable clinical practice and a violation of professional standards. This citation is considered past noncompliance based on the corrective actions implemented by the provider following the incident. Findings include: 1. Review of the provider's submitted SD DOH FRI report revealed that on the night of 3/22/26, at approximately 8:50 p.m., DON B received a verbal telephone order from physician J. Physician J's order was documented in resident 4's electronic medical record for the nursing staff to follow. The physician's order was for resident 4 to receive Lorazepam (a medication to treat anxiety) 0.5 milligrams (mg) (1 tablet) by mouth STAT (to be given immediately or without delay) when resident 3 was experiencing an anxiety episode. This was a new medication order for resident 4 and DON B explained to physician J over the phone that the facility did not have that medication on hand to administer to resident 4. DON B also explained that they could not obtain the medication from the distributing pharmacy at that time since it was closed, and that resident 4's family did not want her sent to the emergency room (ER) for evaluation. Physician J instructed DON B that nurses were to borrow the Lorazepam from resident 3, as resident 3 had Lorazepam 0.5 mg tablets available in the facility. Don B reported to the nursing staff that physician J instructed them to use resident 3's Lorazepam for resident 4 when other comfort or distraction measures failed during resident 4's anxiety episodes. LPN E took a 0.5 mg Lorazepam tablet from resident 3's medication card and gave it to resident 4, who took it orally on 3/23/26 at 12:23 a.m. The Lorazepam was	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 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
F0658 SS = D	Continued from page 8 effective, and resident 4 experienced relief from her anxiety. The FRI report indicated no harm occurred to residents 3 or 4 due to LPN E's actions of administering resident 3's medication to resident 4. DON B sent an order to the pharmacy to replace resident 3's borrowed 0.5 mg Lorazepam tablet. Resident 3's emergency contact and law enforcement were notified of the incident of her medication being used for another resident. The incident was also promptly reported to the SD DOH. 2. A telephone call on 3/25/26 at 2;30 p.m. was attempted with LPN E. There was no answer, and a message was unable to be left on her voicemail to interview her about the above FRI. 3. Interview on 3/25/26 at 4:00 p.m. with administrator A and DON B revealed that the facility failed to maintain professional standards when staff had borrowed resident 3's medication and gave it to resident 4. Administrator A and DON B acknowledged that borrowing medication from a resident was not an acceptable standard of care and that the facility did not follow its policies and procedures for medication ordering or resident treatment. Both Administrator A and DON B stated that this was the first time an incident like this had occurred that involved borrowing medication from a resident. Administrator A said that borrowing a resident's medication for someone else should not have been done, but staff felt there was no other choice at the time. DON B said that resident 3's medication was borrowed for resident 4 because the family refused to send resident 4 to the ER that night, the pharmacy was closed due to off-hours, and no emergency medication kit containing Lorazepam was available to the nursing staff to utilize for resident 4. Administrator A said the issue was promptly identified and that education and interventions were implemented. She stated that physician J and DON B received education on 3/23/26. DON B stated that consultant pharmacist G provided education to the nursing staff on 3/25/26 and that LPN E attended the meeting and was provided with the education. They both acknowledged that audits of incident reporting, including medication availability and not borrowing medications, were being conducted and that the results were being presented at monthly quality assurance meetings.	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 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
F0658 SS = D	Continued from page 9 4. Interview on 3/25/26 at 4:35 p.m. with consultant pharmacist G revealed that she was employed by the local pharmacy and her services for the nursing home were contracted through that pharmacy. She was responsible for the residents' monthly charts and medication reviews. Consultant pharmacist G stated that she helped the nursing home develop policies and procedures for pharmacy services and provided medication information and education to the nursing staff. Consultant pharmacist G acknowledged that borrowing medications from other residents was not standard nursing practice and not an acceptable standard of care. She stated that she provided the nursing staff with education on 3/25/26 regarding the pharmacy services available and the steps the nursing staff was to follow when emergency medications were needed. She said that the pharmacy emergency contact numbers were posted, several pharmacy policies were reviewed, education was provided on the regulations for medication accountability and physician orders for the use of medications for the resident it was ordered for, and advised them to access the tele-health services (a digital technology service provided remotely through a computer to allow healthcare advice or monitoring) available to them. Consultant pharmacist G stated that resident 3's Lorazepam 0.5 mg tablet, which was borrowed for resident 4, was replaced on 3/25/26. She stated that the pharmacy would work with Administrator A and the medical director to implement an emergency medication kit for nursing staff use in emergency situations. 5. Review of the provider's revised January 2018 Medication Orders policy revealed that "Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and recordkeeping requirements in the facility, in accordance with federal and state laws and regulations," and "A chart order is not equivalent to a prescription for controlled drugs. Therefore, the prescriber issuing the chart order must also provide the pharmacist with a valid prescription to ensure	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 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
F0658 SS = D	Continued from page 10 delivery of medication." 6. Review of the provider's revised January 2018 Miscellaneous Special Situations policy revealed that "The facility must make every effort to ensure that medications are available to meet the needs of each resident," and nursing staff shall "Notify the attending physician of the situation and explain the circumstances, expected availability, and optional therapy(ies) that are available," and "Obtain a new order and cancel/discontinue the order for the non-available medication." 7. The provider's implemented actions to ensure that the deficient practice does not reoccur were verified on 3/25/26 after record reviews and interviews revealed that the facility had followed its quality assurance (QAPI) process to maintain acceptable professional standards of clinical practice. Education was provided to the physician and DON on 3/23/26 regarding borrowing any medication, including controlled medications, federal regulations for medication accountability, and physician orders for resident use only. The nursing department received training on 3/25/26 about the facility's medication administration policies, medication delivery, controlled medications, physician orders, pharmacy communication, medication ordering, clarifying orders, and the use of an emergency medication kit. Staff were expected to attend; if unable to do so in person, a Zoom meeting (a virtual, real-time gathering that allows people to connect via video) was available. An education signature sheet was provided, and signatures were recorded. Results of the audits would be reported to the quality assurance committee at their scheduled monthly meetings. Based on the above information, non-compliance at F658 occurred on 3/22/26, and based on the provider's 3/23/26 and additional corrective action plans implemented for the deficient practice confirmed on 3/25/26, the non-compliance is considered past non-compliance.	F0658		