| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 435033 | A. BUILDING _____ B. WING _____ | C 11/21/2024 |

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| WESTHILLS VILLAGE HEALTH CARE FACILITY | 255 TEXAS ST RAPID CITY, SD 57701 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/19/24 through 11/21/24. Westhills Village Health Care Facility was found not in compliance with the following requirements: F558, F600, F684, F699, F812, and F880.<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/19/24 through 11/21/24. Areas surveyed included accidents, employee to resident abuse, nursing services, and quality of care. Westhills Village Health Care Facility was found in compliance. | F 000 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and policy review, the provider failed to ensure in-room call lights were accessible for two of two sampled residents (12 and 33). Findings include:<br><br>1. Observation and interview on 11/19/24 at 9:30 a.m. in resident 33's room revealed:<br>*She sat in her chair with a bedside table beside her.<br>*There was a gray push call light placed on that bedside table that was to her right side. | F 558 | Westhills Village Health Care operates in compliance with all relevant regulations and professional standards in a manner that ensures safe and appropriate care with an emphasis on residents' rights for all residents we serve.<br>In reference to F558, all staff will be educated on proper call light placement and answering call lights in a timely manner and resident rights will be reviewed with all staff on or before December 19th, 2024. Call light audits will be conducted on call light placement and use weekly by Director of Nursing or designee for one month and then monthly for two months. Results will be reviewed by the QAPI committee for recommendations. | 12/19/2024 |

| LABORATORY D | REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|---|
| | Kelsey Bertsch | Executive Director | 12/11/2024 |

Any deficiency : 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 558 | Continued From page 1<br>*She stated around three months ago she did not have her call light when she woke up in the morning, she had to holler to get the attention of a certified nursing assistant (CNA), the CNA came in and told her she had to stop hollering, she was upsetting the other residents.<br>*On the morning of 11/19/24 she did not have her call light and she had to holler to get the attention of the morning CNA.<br>*She stated at times the CNAs put the call light on her left side.<br>-She had a stroke that affected her left side, and she could not use her left hand to push the button on the call light.<br>*The call light that she used was a gray push call light that the CNAs clipped to her shirt or the bed.<br>*She did not have a pendant call light that would have gone around her neck.<br><br>Review of resident 33's electronic medical record (EMR) revealed her 9/7/24 Brief Interview for Mental Status (BIMS) score was 15 indicated she was cognitively intact.<br><br>2. Observation on 11/19/24 at 10:01 a.m. revealed:<br>*During an interview with resident 12's roomate, resident 12 was in her chair in her room.<br>*Resident 12 called out for help.<br>*She said she needed to go to the bathroom but did not have a call light. Her call light was on the floor and out of her reach.<br>*The call light was given to resident 12 and she was able to use it to call for help.<br><br>3. Interview on 11/21/24 at 9:45 a.m. with CNA K revealed:<br>*She would have used the gray push call light and clipped it to the residents' shirt or laid it on the | F 558 | | |

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| F 558 | Continued From page 2<br>residents' tray beside all the residents.<br>*The CNAs also use the gray push call light at night and lay it next to the all the residents in bed.<br>*If the resdients' call lights device had fallen, she would have noticed as she checks on the residents often.<br><br>4. Interview on 11/21/24 at 10:27 a.m. with CNA L revealed:<br>*She would have made sure the gray push call lights were within arm's reach of the residents or made sure they were on the residents' bedside table prior to leaving the room.<br>*She mades sure each resident had two call light options.<br>*The gray push call lights had clips that the CNAs could have clipped to the resident to prevent the call lights from falling.<br>*At night the CNAs would have used the gray push call light and placed them next to the resident or under the sheet and when the resident tried to transfer out of bed it would have alerted the staff.<br>*Depending on the resident, she would have placed the call light on the strongest side of the resident.<br><br>5. Interview on 11/21/24 at 11:00 a.m. with CNA M revealed:<br>*She used the gray push-call light when the resident was in bed.<br>-She would have placed the gray push call light under the sheet or clipped it to the bed.<br>-The gray push call light was rubber and gripped to the sheet to keep it from falling.<br>*If the resident was in their chair, the gray push call light was placed on the bedside table next to them.<br>*If the call lights had fallen or were not in the | F 558 | | |

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| F 558 | Continued From page 3<br>resident's reach she would have noticed as she checked on the residents often.<br><br>6. Interview on 11/21/24 at 12:33 p.m. with director of nursing (DON)/infection control (IC) nurse B revealed:<br>*Her expectation of staff was to place the call lights within reach for the residents and to make sure the residents knew how to use the call lights.<br>*High fall-risk residents used the gray push call light and staff placed it alongside them. The facility had that identified in each of those residents' care plans.<br><br>7. The provider's Call Light policy was requested on 11/21/24 at 10:45 a.m. DON/IC nurse C stated there was no policy that addressed call light accessibility. | F 558 | | |
| F 600 SS=E | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by: | F 600 | Westhills Village Health Care operates in compliance with all relevant regulations and professional standards in a manner that ensures safe and appropriate care with an emphasis on residents' rights for all residents we serve.<br>In reference to F600, staff member CNA N had previously been counseled on 11/15/24 for 2 of 5 concerns that was brought to our attention. CNA N was given additional training on professionalism, customer service, communication skills, and maintaining appropriate relationships with residents and family members on 11/22/24 after the other 3 additional concerns had been brought to our attention. All other 3 residents (19, 35, 33) were followed up on immediately and an immediate investigation was initiated. All findings were unsubstantiated. Through our internal investigation, | 1/5/2025 |

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| F 600 | Continued From page 4<br>Based on observation, interview, and record review, the provider failed to ensure communication and resident care were provided in a dignified manner for five of five sampled residents (19, 24, 31, 33, and 35) by one of one certified nursing assistant (CNA) N. Findings included:<br><br>1. Observation and interview on 11/19/24 at 9:30 a.m. in resident 33's room revealed:<br>*She sat in her chair with a bedside table beside her.<br>*She had a wheelchair and a hemi-walker (specialty walker to aid soneone with limitation on one side of their body) in her room.<br>*She said an assistant told her she had not been walking enough.<br>-She had a stroke that affected her left side and walked with a hemi-walker.<br>*In the mornings when she would wake up, she would be unsteady and would not be ready to walk right away but CNA N would make her walk to the bathroom and the resident feared falling due to weakness on the left side of her body.<br>*Resident 33 stated CNA N's "tone" had not been caring towards her.<br><br>Review of resident 33's electronic medical record (EMR) revealed her 9/7/24 Brief Interview for Mental Status (BIMS) score was 15 indicated she was cognitively intact.<br><br>2. Observation and interview on 11/19/24 at 1:43 p.m. in resident 35's room revealed:<br>*She just finished with restorative therapy and was sitting in her wheelchair.<br>*She stated CNA N had embarrassed her around four months ago when the facility had taken the residents to a local outing. | F 600 | it was reported to the Department of Health and was accepted the same day with unsubstantiated findings. All residents will initially be interviewed to determine all care and communication has been completed in a dignified manner. All staff will be educated on customer services, resident rights, and reporting of abuse/neglect. An audit will be completed by Administrator or designee weekly for one month and monthly for two months on assuring communication and resident care is provided in a dignified manner. Results will be reviewed by QAPI committee for recommendations. | |

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| F 600 | Continued From page 5<br>-CNA N had encouraged resident 35 to go to the outing and when it was time to go CNA N loudly and in front of the other residents, had told resident 35 she could not go as she had not signed up.<br>*Resident 35 stated since that time CNA N seemed obsessed with her and has been in her room, The resident had asked CNA N to come into her room anymore unless she had a reason to.<br>-Two weeks ago, CNA N answered resident 35's call light and assisted her to the bathroom, then when resident 35 came out of the bathroom CNA N was sitting in a chair and was asking resident 35 why she did not like her. Resident 35 explained the embarrassment of the outing.<br><br>Review of resident 35's EMR revealed her 11/1/24 BIMS score of 15 indicated she was cognitively intact.<br><br>3. Interview on 11/20/24 at 1:25 with resident 31's spouse revealed:<br>*She stated she was at the facility 85% of the time visiting her husband.<br>*At first, she thought CNA N was doing a good job then two months ago her attitude towards her husband had changed.<br>*She stated CNA N was not professional with her husband, she was "harsh" with the way she had talked to him.<br>*She stated CNA N's attitude towards her husband was not caring when she took care of him.<br><br>4. Interview on 11/19/24 at 10:14 a.m. with resident 19 regarding how staff cared for her revealed:<br>*CNA N was rude to her, and had told her, "I don't | F 600 | | |

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| F 600 | Continued From page 6<br>like your tone,"<br>*CNA N in the past had refused to take her to the bathroom and said, "You just went 20 minutes ago."<br>*She overheard CNA N tell a new CNA in training, "[resident 19's name] doesn't need to go to the bathroom. That's why they have Depends on."<br><br>Review of resident 19's electronic medical record (EMR) revealed her 8/12/24 BIMS score was "14" which indicated she was cognitively intact.<br><br>5. Interview on 11/20/24 at 3:04 p.m. with resident 24 and his spouse revealed:<br>*"There is one CNA I'm sure you've already heard about, [CNA N]. She is a problem. She's very aggressive."<br>*CNA N was not very professional and had sat on the counter at the nurse's station and ate food.<br>*The resident had dreaded seeing CNA N assigned to his care because CNA N was aggressive and not very patient when providing care.<br><br>Review of resident 24's EMR revealed his 10/24/24 BIMS score was "11" which indicated he had moderate cognitive impairment.<br><br>6. Interview on 11/22/24 at 8:22 a.m. with administrator A regarding the above findings revealed:<br>*She was not aware of any of these issues.<br>*She did not want any resident to feel scared to ask for help.<br>*Her expectation was that staff provide great care to residents and treat them with respect.<br>*A request to interview administrator A with CNA N was declined by administrator A pending discussion with chief executive officer (CEO) P | F 600 | | |

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| F 600 | Continued From page 7<br>and director of nursing/infection control nurse B.<br><br>Interview with CEO P and administrator A on 11/22/24 at 8:36 a.m. and again at 8:47 a.m. revealed:<br>*The incident regarding the outing in resident 35's interview was confirmed.<br>*Professionalism and eating at the nurse's station had been addressed in CNA N's prior performance review.<br>*CNA N was removed from the 11/22/24 schedule pending an internal investigation into the above mentioned allegations.<br><br>Review of the provider's 11/2008 Resident Bill of Rights revealed:<br>*"Quality of Life"<br>-"Our facility must provide care and an environment that contributes to the resident's quality of life including:<br>--"Maintenance or enhancement of the resident's ability to preserve individuality, exercise self-determination and control everyday physical needs."<br>--"Freedom from verbal, sexual, physical and mental abuse and from involuntary seclusion, neglect or exploitation imposed by anyone and theft of personal property." | F 600 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of | F 684 | Westhills Village Health Care operates in compliance with all relevant regulations and professional standards in a manner that ensures safe and appropriate care with an emphasis on residents' rights for all residents we serve.<br>In reference to F684, CNA M was educated on 11/19/24 on proper transfer technique, where weight bearing status is located, and how it is communicated to all staff. | 12/19/2024 |

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| F 684 | Continued From page 8<br>practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to ensure physician's orders were followed for:<br>*Weight-bearing restrictions for one of one sampled resident (40).<br>*A dressing change for one of one sampled resident (22).<br>Findings include:<br><br>1. Observation and interview on 11/19/24 at 9:15 a.m. with certified nurse aide (CNA) M in resident 40's bathroom revealed:<br>*The resident entered the bathroom in her wheelchair wearing a left leg immobilizer.<br>*She twisted her upper extremity to the left and used both of her hands to reach towards the wall-mounted grab bar. She pulled herself up to stand holding those grab bars.<br>-She then pivoted her body holding onto the grab bar and sat down on the toilet seat.<br>*After using the toilet she used the same transferring method to return to her wheelchair.<br>*The resident was pushed out of the bathroom in her wheelchair and positioned in front of her recliner.<br>-She bent forward out of the wheelchair seat to grab the armrest of the recliner, pulled her body towards the chair, pivoted, then sat down in the recliner.<br>*CNA M had not secured a gait belt around the resident's waist prior to either transfer to physically assist her and she had not provided the resident with any verbal cues or instruction during the transfers.<br>-She was unsure if resident 40 had any | F 684 | All nursing staff will be educated on weight bearing status and proper transfer technique on or before December 19th, 2024. Audits of staff knowledge on weight bearing status and proper transfer technique will be completed weekly for one month and monthly for two months by the Director of Nursing or designee.<br>In reference to F684, all nursing staff will be educated on or before December 19th, 2024, on wound care dressing change policy and procedure and following physician order properly. Proper hand hygiene will be included in this education. Audits on wound care dressing/following wound care orders will be conducted weekly by Director of Nursing or designee for one month and monthly for two months as treatments are required in the facility. Results will be reviewed at QAPI for recommendations. | |

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| F 684 | Continued From page 9<br>weight-bearing restrictions.<br><br>Review of resident 40's electronic medical record (EMR) revealed:<br>*Her admission date was 10/30/24 and her admission diagnoses included a left total knee (TKA) arthroplasty explantation (surgical procedure of removing a previously implanted TKA implant), atrial fibrillation, cellulitis and abcess of the left leg, acute respiratory failure with hypoxia, interstitial lung disease, and weakness.<br>*Her 10/30/24 physician discharge orders included the following weight bearing restriction: left lower extremity (LLE) toe touch weight bearing (TTWB).<br><br>Interview on 11/19/24 at 4:00 p.m. with registered nurse H regarding resident 40 revealed:<br>*The resident's weight-bearing status was TTWB with contact guard assistance (CGA) from staff whenever she was up.<br>*A type-written Report Sheet dated 11/19/24 was inside of a clear plastic stand at the nurses' station desk.<br>-That sheet was updated daily and identified pertinent resident-specific information for caregivers to refer to such as a resident's transfer status.<br>-On that sheet beneath the "Transfer Status" column for resident 40: "CGA X1 [caregiver] TTWB with hinge brace LLE."<br><br>On 11/19/24 at 4:10 p.m. director of nursing (DON)/infection control (IC) nurse B was notified of the observation referred to above and CNA M's failure to follow resident 40's physician-ordered weight-bearing restriction. | F 684 | | |

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| F 684 | Continued From page 10<br>Interview on 11/20/24 at 10:15 a.m. with physical therapist (PT) O regarding resident 40 revealed:<br>*She was the primary PT treating resident 40.<br>*Caregivers had been educated by therapy and nursing staff regarding resident 40's mobility and weight bearing restrictions.<br>*Regarding the observation referred to above, PT O stated:<br>-A gait belt was expected to have been placed around the resident's waist prior to the initiation of any transfer. The caregiver should have had their hand on the gait belt to provide the physical support needed to help the resident maintain TTWB status.<br>-Verbal cues and instruction should have been provided by the caregiver throughout the transfer to help the resident maintain TTWB status.<br>-Failure to follow these recommendations placed the resident at increased risk of re-injuring her left knee.<br><br>A Quality of Care policy was requested on 11/20/24 at 5:00 p.m. DON/IC nurse C stated the provider had no policy for that. A Physician's Order policy was provided but only addressed the manner in which physician's orders were obtained and not the expectation of staff to have followed physician's orders.<br><br>2. Observation on 11/19/24 at 10:40 a.m. of licensed practical nurse (LPN) F performing dressing changes on resident 22 revealed:<br>*She had placed dressing supplies on the resident's bedside table without cleaning the surface or providing a clean barrier.<br>*She washed her hands and put on a pair of | F 684 | | |

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| WESTHILLS VILLAGE HEALTH CARE FACILITY | 255 TEXAS ST RAPID CITY, SD 57701 |

| (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 |
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| F 684 | Continued From page 11<br>gloves and with those gloved hands she:<br>-Removed the resident's blankets and rolled her over to her left side.<br>-Soaked a 4 x 4 gauze pad with normal saline and cleaned the wounds to the resident's right leg.<br>-Used a scissors to cut tape and applied a new gauze dressing to the resident's right leg.<br>-Assisted the resident to roll over more onto her left side.<br>-Used the same normal saline soaked gauze that had been on the resident's bed to clean the left leg wound.<br>-Cut a piece of Hydrafera Blue foam to apply to the resident's left leg wound.<br>-Opened the Kerlix gauze package and cut a piece of the Kerlix gauze.<br>-Applied the Hydrafera Blue foam to the resident's left leg wound.<br>-Wrapped the Kerlix gauze to resident's left leg and cut a piece of tape to apply onto the Kerlix dressing.<br>*Removed her gloves and performed hand hygiene.<br>*Applied a liquid bandage to the resident's left heel.<br>*Washed her hands and put on a pair of gloves.<br>*Applied gentamycin ointment to her gloved finger and applied that ointment to the resident's left great toe.<br>*Removed her gloves, did not perform hygiene, and put on a new pair of gloves.<br>*Applied a piece of Kerlix to the resident's toe and applied a piece of tape to secure the Kerlix.<br><br>3. Review of the treatment orders for resident 22 revealed:<br>*On 11/13/24 an order had been placed for wound care to resident's left great toe to include: | F 684 | | |

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| F 684 | Continued From page 12<br>-"Cleanse wound with normal saline, paint with betadine, cover with Hydrafera Blue, cover with 2 x2 and secure with tape."<br>*On 11/13/24 an order had been placed for wound care to resident's right lower extremity to include:<br>-"Cleanse with normal saline, apply Santyl (nickel thick), cover with Hydrefera Blue, cover with 4 x 4, wrap with cast padding, secure with stockinette."<br>*On 11/13/24 an order had been placed for wound care to resident's left lower extremity to include:<br>-"Cleanse with normal saline, apply Santyl (nickel thick), cover with Hydrefera Blue, cover with 4 x4, wrap with cast padding, secure with stockinette."<br>*There had not been an order for gentamycin ointment to have been used during the dressing changes.<br><br>4. Interview on 11/19/24 11:50 a.m. with LPN F regarding the above dressing change revealed:<br>*She had not applied the Santyl cream to the resident's leg wounds, but she did have an order for the gentamycin cream.<br><br>5. Interview on 11/20/24 at 3:15 p.m. with director of nursing B and registered nurse (RN)/infection control G regarding the above observed dressing change revealed:<br>*DON B agreed that LPN F had room for improvement.<br>*DON B agreed that the order had not been followed for the dressing changes for resident 22. | F 684 | | |
| F 699 SS=D | Trauma Informed Care<br>CFR(s): 483.25(m)<br><br>§483.25(m) Trauma-informed care | F 699 | Westhills Village Health Care operates in compliance with all relevant regulations and professional standards in a manner that ensures safe and appropriate care with an emphasis on residents' rights for all residents we serve. | 1/5/2025 |

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| F 699 | Continued From page 13<br>The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the provider failed to ensure two of two sampled residents (15 and 34) were screened for a history of trauma upon their admission to the facility. Findings include:<br><br>1. Observation and interview with resident 15 on 11/19/24 at 2:30 p.m. revealed:<br>*She was in her recliner with her feet elevated.<br>*When asked how she was doing she replied, "How do you think I'm doing?"<br>-She indicated her right arm and shoulder, and her left leg "weren't working." She had arthritis and used either a walker or a wheelchair for mobility.<br>*She was living with her family before she came to the facility. She expected to remain there for long-term care.<br>*She became teary-eyed talking about a flood in 1972 that damaged the family-owned business. In the 2000's, her home was destroyed by a wild fire. One of her sons was developmentally disabled. She voiced regret about having not been more active in things like the PTA (Parent-Teacher Association) when her children were school-aged.<br><br>Review of resident 15's electronic medical record (EMR) revealed:<br>*Her admission date was 10/17/24 and her | F 699 | In reference to F699, a care plan audit will be conducted on all residents for documentation of past traumatic events, if identified with a past traumatic event, an ID note will be completed and care plan will be updated. If past traumatic events are identified, additional services will be offered to those residents. If no past traumatic events are identified, facility will update care plan with no traumatic events identified. Resident 15 and 34 assessed and care plan updated appropriately. Education was provided to Social Service Designee immediately. All new and current residents will be audited on proper assessment and care plan implementation following the critical pathway. This will be conducted weekly for one month and monthly for two months by Social Work Consultant or designee. Results will be reviewed at QAPI for recommendations. | |

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| F 699 | Continued From page 14<br>diagnoses included rheumatoid arthritis, hypokalemia, obesity, obstructive sleep apnea, and atrial fibrillation. She had a history of surgery to her upper right arm bone that had not properly healed.<br>*Social services designee (SSD) I's progress notes since 10/17/24 included the following:<br>-On 10/18/24 she had completed admission paperwork with resident 15. "Resident lives with her daughter and her husband in a private home and goal is to return there."<br>-On 10/30/24 a 5-day assessment note indicated:<br>--A short stay rehabilitation stay was planned for the resident.<br>--The resident's Brief Interview for Mental Status (BIMS) score was a "7" indicating she had severe cognitive impairment.<br>--Her PHQ-2 (a two-question screening tool used to identify depression) score was "0" indicating her mood was not depressed and she never felt lonely or isolated.<br>-On 11/13/24 SSD I met with resident 15's daughter regarding the resident's Medicare-covered services.<br>*Interdisciplinary progress notes between 10/17/24 and 11/20/24 included the following entries:<br>-On 11/15/24 the resident refused her morning care stating she had not wanted to be bothered.<br>-On 11/18/24 an unidentified certified nurse aide (CNA) reported the resident was rude to him and refused care. She called him derogatory names. The CNA stated similar behaviors had been occurring for the past week. An unidentified nurse had spoken with the resident following the incident. The resident acknowledged her behavior but was unapologetic for it. She preferred female staff to care for her and requested not to be disturbed during the night. | F 699 | | |

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| F 699 | Continued From page 15<br>-On 11/20/24 the resident refused morning cares.<br>*There was no assessment in resident 15's EMR that screened for any historical trauma she may have had.<br><br>Interviews on 11/20/24 at 10:04 a.m. with administrator A and social services designee (SSD) I and again on 11/21/24 at 10:00 a.m. with SSD I revealed:<br>*SSD I relied on information shared during admission and initial assessment interviews with resident 15 to have known if she had experienced any historical trauma.<br>-There was no assessment tool available to have formally screened for trauma.<br>*She was not aware of resident 15's life events shared during the 11/19/24 interview referred to above.<br>*SSD I had "some knowledge" of the resident's mood and behavior changes since 11/15/24.<br>*Resident 15's daughter had visited nearly every day but SSD I had not ever discussed with her any past trauma resident 15 may have experienced.<br><br>2. Observation and interview with resident 34 while he had been seated in his wheelchair revealed he had been tearful and had a lot of grief and loss in his life.<br><br>Record review of resident 34's 10/9/24 social services note revealed:<br>*On 10/9/24 a Brief Interview for Mental Status (BIMS) he had scored 5 which indicated he had severe cognitive impairment.<br>*He had received a score of 6 on a PHQ-2 (assessment for depression) which indicated he was mildly depressed.<br>-He had refused counseling services at that time. | F 699 | | |

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| F 699 | Continued From page 16<br>*There had not been any documentation if the resident had been asked about any traumatic events.<br><br>Interview on 11/20/24 at 10:50 a.m. with director of nursing/infection control nurse C and administrator A regarding trauma assessments for residents revealed social services would have asked the resident if they had experienced trauma and would have documented the response in the social services note.<br><br>Interview on 11/20/24 at 2:36 p.m. with social services coordinator I and social services consultant J regarding trauma assessment for residents revealed:<br>*They used the PHQ-2 and the BIMS evaluations of scores to assess for trauma.<br>*Social services consultant J would have asked specifically about trauma and then that usually would start a conversation.<br>*Both agreed that there had not been any documentation in the admission assessment that had indicated if trauma had been screened for resident 34.<br>*Social services consultant J would have expected residents to have been screened upon admission and then quarterly for trauma.<br><br>A Trauma Assessment policy was requested on 11/20/24 at 10:50 a.m. from administrator A. Administrator A and DON/IC nurse C confirmed there was no Trauma Assessment policy and no expectation or process for screening residents for trauma or cultural preferences. | F 699 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) | F 812 | Westhills Village Health Care operates in compliance with all relevant regulations and professional standards in a manner that ensures safe and appropriate care with an emphasis on residents' rights for all residents we serve. | 12/19/2024 |

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| F 812 | Continued From page 17<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and policy review, the provider failed to ensure:<br>*Proper glove use by one of one cook (Q) during two of two observed meal services.<br>*Proper temperature probe cleaning by one of one cook (Q) during one of one observed meal service. Findings include:<br><br>1. Observation on 11/19/24 at 11:06 a.m. of cook Q preparing for the noon-time meal service revealed:<br>*He put on clean gloves, removed waffles from a plastic bag then placed them in a toaster.<br>*Wearing the same gloves he:<br>-Organized serving plates, paper products, and utensils for the meal.<br>-Retrieved hot dog buns and hot dogs from two separate plastic bags. | F 812 | In reference to F812, all staff will be educated on proper glove use, hand hygiene, and proper temping of foods on or before December 19th, 2024. Staff member Q was immediately educated on 11/20/24 on proper glove use, hand /hygiene, and proper temping of foods. This would include using appropriate utensils to avoid cross contaminating food. The Certified Dietary Manager or designee will complete audits weekly for one month and monthly for two months on proper hand hygiene, temping, and appropriate utensils used to avoid cross contamination. Results will be reviewed by QAPI committee for recommendations. | |

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| F 812 | Continued From page 18<br>-Began cutting one of the hot dogs then turned his attention to the waffles that had popped up from inside of the toaster.<br>--Touched the waffles then lowered them back inside of the toaster for additional toasting time.<br>-Resumed cutting the hot dog.<br><br>2. Observation on 11/19/24 at 4:15 p.m. of cook Q temping food for the evening meal service and interview with food services manager (FSM) D at that same time revealed:<br>*In between temping the ground beef, mashed potatoes, gravy, and carrots, cook Q had wiped the temperature probe using a rag from a red bucket that contained a mixture of water and sanitizer.<br>-FSM D stated the use of individual alcohol pads was the preferred method of cleaning the temperature probe in between temping each food item.<br><br>Continued observation at 4:50 p.m. of cook Q plating the evening meal service and interview with FSM D at that same time revealed:<br>*Cook Q used his gloved hands to handle the completed paper menus and individual resident tray cards. He placed both the menus and cards on top of the steam table to refer to as he plated that resident's evening meal.<br>-Wearing the same gloves he grasped a cabinet handle to retrieve individual bags of chips.<br>*He used those now unclean gloves to open up the plastic bag with hamburger buns, remove buns from the bag, and lay them on top of an electric griddle. He handled individually sliced pieces of cheese with the gloves and placed them on top of hamburger patties on the griddle. He removed hamburger patties from the griddle, placed them inside of the warmed buns, then | F 812 | | |

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| F 812 | Continued From page 19<br>moved them to a cutting board. He used the same gloves to hold the hamburger in place while cutting it in half.<br>*He returned to the steam table to continue plating meals without removing his unclean gloves, performing hand hygiene, and putting on clean gloves.<br>*FSM D stated the failure to remove unclean gloves, perform hand hygiene, and apply clean gloves when handling ready to eat foods increased the risk for cross-contamination.<br><br>A Dietary Hand Hygiene and Glove Use policy was requested on 11/20/24 at 8:30 a.m. Director of Nursing/Infection Control Nurse C stated the kitchen staff followed the 4/13/20 Hand Hygiene policy which revealed:<br>*"Proper hand hygiene will be used within the facility to help reduce the possibility of the spread of infection."<br>-There was no mention of expectations for glove use.<br><br>A Food Temping policy was also requested on 11/20/24 at 8:30 a.m. A copy of Chapter 3: Food Production and Food Safety (2021 Becky Dorner) was provided and indicated thermometers used to temp food were expected to be cleaned with an individual alcohol pad, discarded, and a new pad used in between each food that was temped. | F 812 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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 | F 880 | Westhills Village Health Care operates in compliance with all relevant regulations and professional standards in a manner that ensures safe and appropriate care with an emphasis on residents' rights for all residents we serve.<br>In reference to F880, all nursing staff will be educated on or before December 19th, 2024 on wound care dressing change policy and procedure and following physician order properly. | 12/19/2024 |

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| F 880 | Continued From page 20<br>development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. | F 880 | Proper hand hygiene will be included in this education. Random audits on wound care dressing/following wound care orders, oxygen nasal cannula storage, and proper hand hygiene will be conducted weekly by Director of Nursing or designee for one month and monthly for two months as treatments are required in the facility. Results will be reviewed at QAPI for recommendations. | |

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| F 880 | Continued From page 21<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to ensure infection control and prevention practices were maintained:<br>-During wound care performed by one of one licensed practical nurse (F) for one of one sampled resident (22).<br>-For nasal cannula care for two of two sampled residents (15 and 40).<br>-For hand hygiene and glove use during one of one sampled resident's (12) personal care by certified nurse aide (CNA) (K).<br>Findings include:<br><br>1.Observation on 11/19/24 at 10:40 a.m. of licensed practical nurse (LPN) F performing dressing changes on resident 22 revealed: | F 880 | | |

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| F 880 | Continued From page 22<br>*She had placed dressing supplies on the resident's bedside table without cleaning the surface or providing a clean barrier.<br>*She washed her hands and put on a pair of gloves and with those gloved hands she:<br>-Removed the resident's blankets and rolled her over to her left side.<br>-Soaked a 4 x 4 gauze pad with normal saline and cleaned the wounds to the resident's right leg.<br>-Used a scissors to cut tape and applied a new gauze dressing to the resident's right leg.<br>-Assisted the resident to roll over more onto her left side.<br>-Used the same normal saline soaked gauze that had been on the resident's bed to clean the left leg wound.<br>-Cut a piece of Hydrafera Blue foam to apply to the resident's left leg wound.<br>-Opened the Kerlix gauze package and cut a piece of the Kerlix gauze.<br>-Applied the Hydrafera Blue foam to the resident's left leg wound.<br>-Wrapped the Kerlix gauze to resident's left leg and cut a piece of tape to apply onto the Kerlix dressing.<br>*Removed her gloves and performed hand hygiene.<br>*Applied a liquid bandage to the resident's left heel.<br>*Washed her hands and put on a pair of gloves.<br>*Applied gentamycin ointment to her gloved finger and applied that ointment to the resident's left great toe.<br>*Removed her gloves, did not perform hygiene, and put on a new pair of gloves.<br>*Applied a piece of Kerlix to the resident's toe and applied a piece of tape to secure the Kerlix. | F 880 | | |

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|---|---|---|---|
| | 435033 | A. BUILDING _____ B. WING _____ | C 11/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTHILLS VILLAGE HEALTH CARE FACILITY | 255 TEXAS ST RAPID CITY, SD 57701 |

| (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 |
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| F 880 | Continued From page 23<br>Observation of 11/19/24 at 10:55 a.m. of LPN F revealed the scissor she had used resident 22's dressing changes had not been cleaned or disinfected prior to returning it to the treatment cart.<br><br>Interview on 11/19/24 11:50 a.m. with LPN F regarding the above dressing changes revealed she:<br>*Had not realized she had used the same pair of gloves during the entire dressing change.<br>*Had not thought to have used a clean cotton tipped applicator to apply the ointment to resident's wound versus her gloves.<br>*Had not cleaned or disinfected the scissor she had used during the dressing change prior to placing it in the treatment cart.<br>*Agreed that she had not cleaned the surface or applied a barrier for the dressing supplies.<br><br>Interview on 11/20/24 at 3:15 p.m. with director of nursing B and registered nurse (RN)/infection control G regarding the above observed dressing change revealed:<br>*DON B agreed that LPN F had not followed their dressing change policy.<br><br>Review of the provider's April 2018 Dressing Change (Clean) Guidelines revealed:<br>*"Place items on clean field. Arrange items on field in order of use."<br>*"Position resident."<br>*"Remove gloves, wash hands (or use alcohol based hand rub) and scissors."<br>*"Don gloves, removed soiled dressings, note any important clinical characteristics of the soiled dressing and discard appropriately."<br>*"Remove gloves, discard appropriately."<br>*"Wash hands or use alcohol based hand rub." | F 880 | | |

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| | 435033 | A. BUILDING _____ B. WING _____ | C 11/21/2024 |

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|---|---|
| WESTHILLS VILLAGE HEALTH CARE FACILITY | 255 TEXAS ST RAPID CITY, SD 57701 |

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| F 880 | Continued From page 24<br>*"Don gloves and utilizing aseptic (clean) technique, moisten gauze pad with wound cleanser or normal saline, if applicable. Clean wound using a circular motion starting from the center towards the outside."<br>*"Remove gloves, discard appropriately."<br>*"Wash hands or use alcohol based hand rub."<br>*"Swab scissors with alcohol wipe if used and wash hands or use alcohol based hand rub."<br>*"Don gloves for topical/dressing application utilizing aseptic technique."<br>-"If topical is used, apply with clean cotton applicator."<br>*"If more than one wound is being treated, gloves should be removed, hands washed and fresh gloves applied for each wound."<br>-"Follow same procedure for each wound site."<br><br>2. Observation on 11/19/24 at 9:34 a.m. revealed resident 15's nasal cannula was lying on the floor in her room.<br><br>Observation on 11/19/24 at 4:23 a.m. revealed resident 40's nasal cannula lying on the floor in her room and the portable oxygen nasal cannula wrapped around the oxygen tank on her wheelchair.<br><br>Interview on 11/19/24 5:14 p.m. with registered (RN) H regarding the storage of resident's nasal cannulas revealed the floor was not a clean area for nasal cannulas to be stored.<br>*Wrapping oxygen tubing around a portable oxygen tank on resident's wheelchair would not be a clean area to store the tubing.<br><br>Interview on 11/20/24 at 3:40 p.m. with RN/Infection Control G regarding resident's nasal cannulas lying on the floor or wrapped around a | F 880 | | |

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| | 435033 | A. BUILDING _____ B. WING _____ | C 11/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WESTHILLS VILLAGE HEALTH CARE FACILITY | 255 TEXAS ST RAPID CITY, SD 57701 |

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| F 880 | Continued From page 25<br>portable oxygen tank when not in use revealed that would be an infection control concern.<br><br>3. Observation on 11/19/24 at 9:15 a.m. of certified nurse aide (CNA) M assisting resident 40 in her bathroom revealed:<br>*The resident's nasal cannula was pulled out of her nose then dropped to the floor in front of the toilet when she transferred from her wheelchair onto the toilet seat.<br>*After wiping the resident's peri-area with her gloved hands CNA M, without removing her unclean gloves, picked up the nasal cannula from off the floor and handed it to the resident to put back inside her nose.<br><br>Continued observation and interview with CNA M after resident 40 exited her bathroom revealed:<br>*The resident transferred from her wheelchair to a recliner in her room. She removed the nasal cannula connected to her portable oxygen and hung it over the back of her wheelchair.<br>*CNA M retrieved a second nasal cannula and attached it to the resident's oxygen concentrator.<br>-That cannula was laying underneath a reacher (adaptive grabbing device) and around a wheelchair footrest on the seat of a chair. | F 880 | | |

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| | 435033 | A. BUILDING _____ B. WING _____ | C 11/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTHILLS VILLAGE HEALTH CARE FACILITY | 255 TEXAS ST RAPID CITY, SD 57701 |

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| F 880 | Continued From page 26<br>*Without first cleaning that cannula CNA M handed it to the resident who placed it inside of her nose.<br>*CNA M confirmed she should have cleaned both cannulas with an alcohol pad before she handed them to the resident to place inside of her nose.<br><br>Review of the provider's 5/29/07 Oxygen Concentrators policy revealed:<br>*Maintenance:<br>-"Cannulas will be changed twice per month or more often if necessary for infection control."<br>*There was no instruction regarding how a nasal cannula was expected to have been stored to mitigate the risk for contamination.<br>4. Observation on 11/21/24 at 9:40 a.m. with CNA K assisting resident 12 in her bathroom revealed:<br>*CNA K assisted the resident onto the toilet and removed and discarded resident 12's wet brief with her bare hands.<br>*CNA K performed hand hygiene, applied gloves, and wiped bowel movement off the resident's buttocks.<br>*CNA K used those same soiled gloves and applied barrier cream to the resident's buttocks area.<br>*After applying the cream, the CNA removed those gloves and did not perform hand hygiene before assisting the resident with pulling up her clean brief and pants, and transferring to her wheelchair.<br>*CNA K did not perform hand hygiene before assisting the resident with her oral cares, or before assisting the resident with transferring from her wheelchair to her recliner.<br>*CNA K did not perform hand hygiene after exiting the resident's room.<br><br>*CNA K had infection control concerns during the | F 880 | | |

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| F 880 | Continued From page 27<br>resident's personal care when she failed to:<br>-Use gloves when handling a urine-soaked brief<br>-Perform hand hygiene after handling the soiled brief and before handling a clean brief<br>-Remove gloves, perform hand hygiene, and re-glove after wiping bowel movement off of resident and before applying barrier cream.<br>-Perform hand hygiene after barrier cream application and before assisting with oral cares.<br>-Perform hand hygiene after assisting with oral cares.<br>-Perform hand hygiene after exiting the resident's room.<br><br>Interview on 11/21/24 at 12:09 with RN G and the IC Nurse regarding the above observations revealed:<br>*She would have expected staff to use standard precautions (the basic level of infection control practices that should always be used when providing patient care) when assisting residents with toileting, personal care, and providing oral care.<br>*She agreed that CNA K did not follow infection control and hand hygiene policies.<br><br>A review of the provider's 4/13/20 Hand Hygiene policy revealed:<br>*"Indications"<br>-"Hand hygiene should be done by staff:<br>--Before and after physical contact with a Resident, whether or not gloves are worn, and between different site/care activities on the same Resident.<br>--After contact with a Resident or Resident's body fluids, including specimen collection.<br>--After contact with soiled linens, dressings, or equipment." | F 880 | | |

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| WESTHILLS VILLAGE HEALTH CARE FACILITY | 255 TEXAS ST RAPID CITY, SD 57701 |

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| F 880 | Continued From page 28<br>A review of the provider's 04/2024 Infection Control Precautions policy revealed:<br>*"Types of Precautions"<br>-"Standard Precautions are for all residents all the time. They are the basic level of infection control precautions. Standard precautions include:<br>--Hand hygiene<br>--Personal protective equipment (gowns, gloves and eye protection, as appropriate)" | F 880 | | |

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

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|---|---|---|---|
| | 435033 | A. BUILDING _____ B. WING _____ | 11/19/2024 |

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| E 000 | Initial Comments<br><br>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 11/19/24. Westhills Village Health Care Facility was found in compliance. | E 000 | | |

| LABO | IDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|---|
| | Kelsey Bertsch | Executive Director | 12/11/2024 |

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| | 435033 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/19/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **WESTHILLS VILLAGE HEALTH CARE FACILITY** | **255 TEXAS ST**<br>**RAPID CITY, SD 57701** |

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| K 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted on 11/19/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Westhills Village Health Care Facility was found in compliance. | K 000 | | |

LABORATOR Kelsey Bertsch JPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 12/11/2024

Any deficien erisk (*) 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.

South Dakota Department of Health

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| | 10721 | A. BUILDING: _____ B. WING _____ | 11/21/2024 |

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| WESTHILLS VILLAGE HEALTH CARE FACILITY | 255 TEXAS ST RAPID CITY, SD 57701 |

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| S 000 | Compliance/Noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/19/24 through 11/21/24. Westhills Village Health Care Facility was found in compliance. | S 000 | | |
| S 000 | Compliance/Noncompliance Statement<br><br>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 11/19/24 through 11/21/24. Westhills Village Health Care Facility was found in compliance | S 000 | | |

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

Kelsey Bertsch | Executive Director | 12/11/2024