STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435105	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheatcrest Hills Healthcare Center	**1311 VANDER HORCK ST , BRITTON, South Dakota, 57430**

(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 from 8/18/26 through 8/19/26. Areas surveyed included quality of care related to timely incontinence (involuntary urine or bowel leakage) care, the availability of medical supplies, staff interactions with the residents, and potential staff-to-resident abuse. Wheatcrest Hills Healthcare Center was found to have past-compliance at F600.	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 South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and observation, the provider failed to protect the resident's right to be free from physical abuse for one of one sampled resident (1) who reported he was slapped in the face by one of one certified nurse aide (CNA)/bath aide (D). This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include:	F0600	"Past Noncompliance - no plan of correction required"	

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
Ada Mundt	Administrator	8/25/2026

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F0600 SS = D	Continued from page 1 1. Review of the provider's 5/25/26 SD DOH FRI revealed that on 5/25/26 at 7:30 a.m., CNA B reported to registered nurse (RN) C that resident 1 told her that CNA/bath aide D slapped him across the face. Resident 1 stated CNA/bath aide D wanted him to take a bath, but he did not want a bath. He hit CNA/bath aide D, then CNA/bath aide D slapped him on the face. Resident 1 stated that the slap was "hard and hurt." CNA/bath aide D's witness statement regarding the above incident revealed that she indicated she "patted" the resident 1's face, not slapped it, after the resident hit her. Resident 1 was assessed for any physical injury after the incident, and he was offered the opportunity to speak with a counselor regarding the incident. On 5/26/26, all the residents were interviewed to determine if any staff had treated them roughly or if they were fearful of any staff. Skin checks were completed for all non-interviewable residents, and administrator A reviewed the April 2026 and May 2026 Incident Tracking Log data for skin tears, abrasions, or bruises on residents who were cared for by CNA/bath aide D. The administrator provided all staff education regarding how to properly respond to residents' verbal and physical aggression toward the staff. Weekly audits were initiated that included resident interviews regarding the staff's treatment towards them and, if the residents felt safe within the facility. The provider ensured that resident 1's care plan was reviewed and updated related to behavior management interventions. Resident 1's family, his medical provider, and the local law enforcement were notified of the above incident. The provider verified the allegation of resident abuse, and CNA/bath aide D's employment at the facility was terminated on 5/27/26. The incident was brought to the facility's Quality Assessment and Performance Improvement (QAPI) meeting for further review by that interdisciplinary team. 2. Review of resident 1's electronic medical record (EMR) revealed that his 6/10/26 Brief Interview for Mental Status (BIMS) assessment score was "14," which indicated his cognition was intact. His diagnoses included an anoxic brain injury (a non-traumatic injury that occurs when the brain gets no oxygen), Parkinson's disease (a brain disorder that affects movement, balance, and coordination), and depression. Resident 1's revised 5/26/26 care plan (a personalized plan that addresses a resident's care needs, goals, and interventions)	F0600		

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F0600 SS = D	Continued from page 2 identified that his impulse control was impaired, he had refused bathing at times, had the potential to be combative with care, and cursed at the staff. There were individualized interventions for the staff to implement to manage those behaviors. 3. Interview on 8/18/26 at 3:45 p.m. with RN C regarding resident 1's behavior revealed that the resident liked a consistent schedule, and he was compliant with the nursing care that she provided him with. 4. Observation and interview on 8/18/26 at 4:35 p.m. with CNA E in resident 1's room revealed that she transferred resident 1 from his recliner to the toilet using a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position). CNA E approached resident 1 calmly and explained what she was doing throughout the transferring process. Resident 1 was cooperative throughout that care activity. CNA E knew that resident 1 had the potential to be aggressive towards the staff at times. He was sometimes impatient with the staff. CNA E stated that all staff received education regarding how to manage residents who had behavioral concerns, such as aggression. 5. Interview on 8/18/26 at 5:00 p.m. with resident 1 in his room revealed that he shook his head up and down and verbalized affirmatively that the staff treated him with respect, his care needs were met to his satisfaction, his call light was answered promptly, and he felt safe. 6. Interview on 8/19/26 at 12:05 p.m. with CNA/bath aide F revealed that there were a few residents who had challenging behaviors such as aggression or resistance to care. She stated that a “group effort” [all the staff working together] was required to ensure those residents’ care needs were met. CNA/bath aide F indicated residents “couldn’t be forced” to do something they did not want to do. She approached the residents unhurriedly, spoke calmly to them, and explained what she was doing while providing their care. Sometimes, she had to reapproach a resident or have another staff person complete a resident’s care if that resident was agitated or was refusing care. She felt that resident 1 was cooperative with her when she bathed him. 7. The provider’s implemented actions to mitigate the likelihood of the deficient practice from reoccurring were verified on 8/19/26 after record review, staff interviews, resident interviews, and interview with administrator A revealed that the facility had followed its QAPI process regarding	F0600		

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F0600 SS = D	Continued from page 3 physical abuse towards residents. Based on the above information, non-compliance at F600 occurred on 5/25/26, and based on the provider's corrective action plans that were initiated on 5/25/26 and implemented for the deficient practice confirmed on 8/19/26, the non-compliance is considered past non-compliance.	F0600		