PRINTED: 07/03/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		435105	B. WING			C 06/18/2025	
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		10/2020
				13	11 VANDER HORCK ST		
WHEATCR	WHEATCREST HILLS HEALTHCARE CENTER			В	RITTON, SD 57430		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG			PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	- 1	1. Turchus regidente effected. These regi	donto	
					Twelve residents affected. These residents affected.		
		rvey for compliance with 42			restorative plans and care plans review		
	•	rt B, requirements for Long			6/18/25 and updated to reflect restoration	ve	
		as conducted from 6/17/25			program up to 5 times per week.		
		area surveyed was quality					
	of care and treatment				2. All residents have the potential to be		
		nt bathing. Wheatcrest Hills			affected. A facility wide audit of all reside	ents	
Healthcare Center was found not in compliance with the following requirement: F688.				care needs was conducted. Any resident	ts		
F 688		crease in ROM/Mobility	F6	888	identified as having restorative needs but	ıt not	
SS=E	CFR(s): 483.25(c)(1)-(3)				actively receiving services per care plan	had	
	- () ()()	(-)			their care reviewed and care plan update	ed.	
	§483.25(c) Mobility.						
		ility must ensure that a		(3. The ED, DNS, and SDC have reviewe	d the	
		ne facility without limited			restorative program policy by 6/20/25. The		
		not experience reduction in			or designee will educate nursing staff reg		
	_	s the resident's clinical			charting appropriately and timely if doing		
	of motion is unavoidal	es that a reduction in range			exercises with the residents by 6/26/25.	-	
	of motion is unavolual	pie, and		- 1	not working will be educated prior to the		
	§483.25(c)(2) A reside	ent with limited range of		- 1	their next working shift. The Activities Dir		
	motion receives appro			- 1	educated 6/18/25 when doing group exe		
	services to increase ra	ange of motion and/or to			to chart under restorative tasks.		
	prevent further decrea	ase in range of motion.					
	\$400.0E(a\/0\ A == 11	and with limitant mark little		.	4. The DNS or designee will audit 4 resid	dent's	
		ent with limited mobility services, equipment, and		- 1	restorative charting weekly times 8 week		
		n or improve mobility with			then monthly times two months to ensure		
		able independence unless a			restorative is being provided as care plar		
	-	s demonstrably unavoidable.			The DNS or designee will audit 4 residen		
	·	is not met as evidenced			participating in restorative program week		
	by:			- 1	times 8 weeks and then monthly times 2	- 1	
		n, interview, record review,		t	to ensure restorative program is being pr	ovided	
		provider failed to ensure an			as care planned.		
	ongoing restorative nu	0. 0		-	The DNS or designee will bring the resul	ts of	
		to residents' care planned			these audits to the monthly QAPI commi		
	2, 3, 4, 5, 6, 7, 8, 9, 10	velve sampled residents (1,			further review and expectations to contin	nue or	7/11/2025
	2, 3, 4, 3, 0, 1, 0, 9, 10	o, 11, 12 j at 113 n 101 a			discontinue the audits.		
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	·		TITLE		(X6) DATE

RATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATU

Ada Mundt

Executive Director

7/9/2025

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		435105	B. WING		C 06/18/2025
	ROVIDER OR SUPPLIER	ARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 311 VANDER HORCK ST BRITTON, SD 57430	1 00/10/2020
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 688	a.m. with resident of *He had lived at the *He had received the admitted, but his the *His physician and him that he would resident of the varied or occurred. *He expressed his he would like his restorative proweek and varied or occurred. *He expressed his he would like his restorative proweek and varied or occurred. *He expressed his he would like his restorative prowed his he would like his restorative program eventually his foliation of the second his discharge home. Interview on 6/17/2 aide (RA) E regard program revealed: *She stated that the up resident 1's restorated that the up resident 1's restorated on Tues *His ROM exercise TheraBands for his and kicking exercise -TheraBands are e training and stretch increase flexibility a -Squeeze balls are exercise the muscle	motion (ROM). interview on 6/17/25 at 10:41 I and his wife revealed: e facility since January 2025. herapy services when he erapy program had ended. therapist had mentioned to hever walk again. gram was completed once a h which day of the week it desire to return home and that storative program to be daily. ad a care conference on the he asked staff about adding to his restorative program. Stated she could not see how the would be possible. 5 at 1:04 p.m. with restorative ing resident 1's restorative the therapy department had set orative program to be days and Thursdays. s included the use of upper ROM, squeeze balls, es. lastic bands used for strength ing various muscle groups to and ROM. small flexible balls used to es of the hands, fingers, and	F 688		
	increase flexibility a -Squeeze balls are exercise the muscle wrists, that can impand ROM. *She stated resider	and ROM. small flexible balls used to			

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F 688	Continued From pag	ge 2	F 6	888			
		she would not be able to ative programs that day.					
	*He was admitted or *His diagnoses include hemorrhage with losserious head injury to between the brain at trauma, causing term unconsciousness), losymptomatic epileps with complex partial where seizures origing the brain and involved awareness), other firsubsequent encount routine healing, Parlia group of neurologis similar movement symovement, and stifff ischemic attack (offet temporary disruption causing stroke-like siminutes to hours, but "His most recent sig Minimum Data Set (assessment references "Functional Limitative extremity (hip, kneedes "Impairment on bott "A Restorative Progrataff development red 4/17/25 indicated the was recommended to the street and the street in th	ded traumatic subdural is of consciousness (a where bleeding occurs and its outer covering due to apporary or prolonged ocalization-related by and epileptic syndromes seizures (a type of epilepsy mate from a specific area of ea a loss or alteration of acture of right lower leg, ter for closed fracture with kinsonism (a general term for cal disorders that share ymptoms like tremors, slow mess), and transient cerebral en called a mini-stroke, and of blood flow to the brain, symptoms that resolve within at typically within 24 hours). Inificant change in status MDS) assessment with an oce date of 3/3/25 indicated: On in Range of Motion: Lower ankle, foot)." The sides." The sides of the times per week. The times per week. The times per week. The times per week. The times to the times per week. The times times and the times per week. The times times times are the times per week. The times times times are times and the times per week. The times times times are times and times are times are times and times are times are times and times are times and times are times and times are times are times and times are times are times are times and times are times are times are times and times are times					

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		435105	B. WING			1	C 18/2025	
	ROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE 311 VANDER HORCK ST	1 00/	16/2025	
WHEATCH	REST HILLS HEALTHCA	RE CENTER		В	BRITTON, SD 57430			
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F 688	to]: decreased ROM. and] decreased trans -A goal of, "I would like level of functioning." -An intervention of, "NREHAB/RESTORATI Exercise group for 15 [Tuesday, Thursday f [Monday, Wednesday times per week[.]"Job positions respocertified nursing assistant (RN*His 6/18/25 point of for the past 30 days f restorative program in from 5/20/25 through recorded for the quesspent providing Rang that indicated: -On 5/22/25 at 10:28 Available[.]" -On 6/3/25 and 6/9/25 1 had completed five each of those two darang the control of the past 30 days with the control of the past 30 days for the past 30	in indicated: Impaired mobility R/T [related decreased bed mobility.], Ifer skills." Ite to maintain my current NURSING VE: ACTIVE ROM Program: Ite min.[minutes] Tue-Thurs Ite for] Flexibility. Mon-Wed-Fri Ity, Friday for] Strengthening 3 Insible for that included Istant (CNA) and restorative ItA). Ite care (POC) response history Ite above nursing Indicated there were 21 days Ite of Motion [ROM] (active)" In a.m. the "Resident [was] Not Ite, both at 1:59 p.m., resident Iminutes of active ROM on Ite of State 2:09 p.m. with resident Ite of in the restorative Ite of minutes Ite of active ROM on Ite of State 2:09 p.m. with resident Ite of in the restorative Ite of motion [ROM] (active) Ite of state 2:09 p.m. with resident Ite of in the restorative Ite of state 2:09 p.m. with resident Ite of state 2:09 p.m. with	F	688				

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		435105	B. WING _			06/1	8/2025	
	ROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CIT 1311 VANDER HORCK BRITTON, SD 57430	ST	1 00/1	0/2023	
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F 688		and 3's restorative program	F	888				
	program every day the Review of resident 2'							
	an assessment reference indicated:	rterly MDS assessment with						
	extremity (shoulder, e -"Impairment on one *A Restorative Progra	elbow, wrist, hand)."						
	exercise group progra was recommended for -A NuStep is a bike-li	am and "NuStep" program or resident 2. ke therapy machine that						
	in a seated positionNo frequency was in	lower body movement while dicated. essment score was 11						
	which indicated he wi impaired. *His 6/18/25 care pla	as cognitively moderately n indicated:						
	to]: decreased ROM, skills."	mpaired mobility R/T [related [and] decreased ambulation te to maintain my current						
	level of functioning." -An intervention of, "N	•						
	Thursday for] Flexabi [Monday, Wednesday -An intervention of, "N							
	NuStep level 5 for 15	VE: ACTIVE ROM Program: min 5 times per week." nsible included CNA and						

T '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	COMPLETED
		435105	B. WING		C 06/18/2025
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(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 688	for the past 30 days programs: -Indicated there we through 6/17/25 that the question "Amou Range of Motion [R-On 6/17/25 at 1:59 ROM had been corhis restorative programe to the was admitted of the was admit	point of care) response history of for the above restorative re four days from 5/20/25 at had responses recorded for ant of minutes spent providing (OM] (active)" that indicated: 0 p.m., fifteen minutes of active inpleted for that day for both of rams noted above. 1 ys were "Not Applicable[.]" 3's EMR revealed: 1 on 3/25/20. 1 arterly MDS assessment with erence date of 3/19/25 Functional Limitation in Range "Upper extremity (shoulder, and "Lower extremity (hip, eram Referral Form signed by RN C on 1/8/25 indicated a pup program and "NuStep" inmended for the resident five a aintain current level of assessment score was 15 was cognitively intact. Ian indicated: "Impaired mobility R/T [related M." like to maintain my current unctioning"	F 68		

[` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 688	NuStep to all extrer week" Job positions resp and RNA. *His 6/18/25 POC (for the past 30 days programs: -Indicated there we 5/20/25 through 6/1 recorded for the qu spent providing Railland From 1.2 (a) and the spent providing Railland From 1.2 (b) and the spent providing Railland From 1.2 (c) and the spent providing Railland From 1.2 (c) at 1.3 (c) at 1.5	"NURSING TIVE: ACTIVE ROM Program: mities for 15 minutes 5 times a consible for that included CNA point of care) response history is for the above restorative re twenty-four days from 17/25 that had responses estion "Amount of minutes inge of Motion [ROM] (active)." indicated active ROM was 5 p.m. for 15 minutes for the program. 6 p.m. for 15 minutes for the orative program. 2 p.m. for 15 minutes for the utes for the exercise group. , and 6/17/25, all at 1:59 p.m., both restorative programs. 9 p.m., the "Resident	F 688				
	_						

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F 688		ne 7 eoarthritis, characterized by and limited range of motion in	F 6	588			
	multiple joints, often knees, and hips). *Her most recent qu an assessment refer indicated: -"Functional Limitation extremity (hip, knee,	affecting hands, spine, arterly MDS assessment with ence date of 5/13/25 on in Range of Motion: Lower ankle, foot)."					
	-"Impairment on both sides." *A Restorative Program Referral Form signed on 4/24/24 indicated that individual exercises were recommended five times a week for the resident. *Her 5/13/25 BIMS assessment score was five which indicated she was severely cognitively impaired.						
	*Her 6/18/25 care pl -A problem area of " to]: decreased ROM and] decreased tran	Impaired mobility R/T [related [,] decreased bed mobility[,					
	-Interventions of, "NI REHAB/RESTORAT ACTIVE ROM Proof 15 minutes on Tuesof flexibility and on More						
	extremities for 15 mi Transfer Program: frequency indicated. Job positions response	gram: In-room exercises to all nutes five times a week. Sit-to-Stand training with no					
	history for the past 3 restorative programs -Indicated there were	point of care) response 0 days for the above s: e twenty-five days from 7/25 that had responses					

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F 688	spent providing Rar -On 5/23/25 at 10:50 completed fifteen m -On 5/30/25 at 1:52 completed five minu-On 6/17/25 at 1:59 completed ten minu-The other 22 days Applicable[.]" 4. Review of resider *He was admitted o *His diagnoses inclu (occurred when the leading to cell death repeated falls, and I progressive neurodoprimarily affects mo *His most recent an an assessment refeindicated Functional Motion to both the unextremities with imp *A Restorative Progressif development Resided individual exercises times a week to main functioning with sit-times and the sit-times	estion "Amount of minutes age of Motion [ROM] (active)." O a.m., resident 4 had inutes of active ROM. p.m., resident 4 had attes of active ROM. p.m., resident 4 had attes of active ROM. p.m., resident 4 had attes of active ROM. had responses of "Not had responses	F 6	88			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	435105	B. WING		,	C 06/18/2025	
NAME OF PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	· ·	J6/16/2025	
			1311 VANDER HORCK ST			
WHEATCREST HILLS HEALTHCA	RE CENTER		BRITTON, SD 57430			
PREFIX (EACH DEFICIENC	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 688 Continued From page	e 9	F 68	38			
"ACTIVE ROM Progall his extremities forTransfer Program: Sfrequency indicatedJob positions responsed and RNA. *His 6/18/25 POC (position for the past 30 days in programs indicated the from 5/20/25 through responses that indicated that was conspected in the past 30 days in programs indicated the from 5/20/25 through responses for the quasion for the past 30 days in the programs indicated that was conspected in the past 30 days in the program of the providing and skindicated that was conspected in the past 30 days in the providing Range of Market 19 days in the providing resident 6's revealed that he need participate in his rest frequently refused to the providing Range of Market 19 days in the providing resident 6's revealed that he need participate in his rest frequently refused to the providing Range of Market 19 days in the providing resident 6's revealed that he need participate in his rest frequently refused to the providing Range of Market 19 days in the providing Range 19 days in the providi	gram: In room exercises to 15 minutes 5 times a week." Sit-to-Stand training" with no unsible for that included CNA bint of care) response history for the above restorative here were twenty-six days 6/17/25 that had recorded heted: huestion "Amount of minutes ill practice in transfer" hampleted: home five minutes. had responses of "Not hount of minutes spent hotion [ROM] (active)." home for ten minutes. had responses of "Not hourt of minutes and responses of "Not hourt of minutes. had responses of "Not hourt of minutes. had responses of "Not hotion [ROM] (active)." home for ten minutes. had responses of "Not	F 68	38			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 688	weakness on one sin hemiparesis (weakn following cerebral in part of the brain is discontinuous blood supply) affectives vascular dementia, a osteoarthritis (the mosteoarthritis, charastiffness, and limited joints, often affecting hips). *His most recent quant an assessment refer indicated: -"Functional Limitation both upper and lower on one side. *A Restorative Programmer Restoration of the programmer in the part of the programmer in the part of the part	ded hemiplegia (severe de of the body) and ess on one side of the body) farction (a condition where a amaged due to a lack of ng right dominant side, and primary generalized ost common type of cterized by joint pain, I range of motion in multiple g hands, spine, knees, and	F	688		
	a week for the reside *His 6/3/25 BIMS as which indicated he w impaired. *His 6/18/25 care pla -A problem area of " to]: decreased ambu -A goal of, "I would I level of functioning." -Interventions of NU REHAB/RESTORAT"ACTIVE ROM Pro upper extremities fo"Transfer Program training."	sessment score was nine, vas cognitively moderately an indicated: Impaired mobility R/T [related ulation skills." ike to maintain my current RSING				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 688	for the past 30 days programs indicated to 5/20/25 through 6/17 responses recorded -For the question "A training and skill praOn 6/17/25 at 1:59 completed two minuThe other ten days Applicable[.]"No responses had refusedFor the question "A providing Range of Neleven responses weNo responses had refused. 6. Interview on 6/17/7 in her room reveal *Had lived at the fact half. *Participated in the room Monday, Wednesda *Stated the staff did restorative exercises Review of resident 7 *She was admitted of *Her diagnoses incluced to the narrow, putting presenerves, which cause weakness in the ned age-related osteopo weakens bones, mat to fractures), and pri	for the above restorative there were eleven days from 7/25 that had the following mount of minutes spent ctice in transfer." p.m., resident 6 had tes. had responses of "Not indicated the resident had mount of minutes spent Motion [ROM] (active)" all there "Not Applicable[.]" indicated the resident had 25 at 2:31 p.m. with resident ed she: illity for the past year and a sestorative program on y, and Fridays. a good job with the sand had no concerns. "Is EMR revealed: on 8/28/23. Inded spinal stenosis (a spaces within your spine sure on the spinal cord and its pain, numbness, and its, back, arms, or legs), rosis (a bone disease that king them more susceptible	F 68	38		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		COMPLETED
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	AME OF PROVIDER OR SUPPLIER WHEATCREST HILLS HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP 1311 VANDER HORCK ST BRITTON, SD 57430	CODE	1 00/10/2023
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B THE APPROPRIA	
F 688	an assessment reference indicated: -"Functional Limitation both upper and lower on one side. *A Restorative Prograstaff development RN group exercises, Nustraining programs were a week for the reside *Her 6/10/25 BIMS a which indicated she wimpaired. *Her 6/18/25 care planary and the side of the reside and decreased ROM[and] decreased ROM[and] decreased ambiguity and decreased ambiguit	ence date of 6/10/25 In in Range of Motion" for rextremities with impairment am Referral Form signed by C on 6/13/25 indicated Step, and Walk-to-Dine are recommended five times int. It is seessment score was ten, was cognitively moderately an indicated: Impaired mobility R/T [related of coreased transfer skills], ulation skills." Imaintain my current level of RSING IVE: In gram Exercise group for 15 I exibility [and] I trengthening." I gram: NuStep at level 5 for a week." I walk with walker and one PRN [as needed]." I insible for that included CNA I oint of care) response I days for the above	F	588		
	were three responses On 6/13/25 and 6/1 "Not Applicable".	ge of Motion (active)", there s: 4/25 the responses were p.m., the response of ten				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		(X3) DATE SURVEY COMPLETED
		435105	B. WING		C 06/18/2025
A BUILDING B. WING NAME OF PROVIDER OR SUPPLIER WHEATCREST HILLS HEALTHCARE CENTER STREET ADDRESS, CITY, ST 1311 VANDER HORCK ST BRITTON, SD 57430 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERE		1 00/10/2023			
PRÉFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 688	minutesFor the NuStep "A providing Range of three responses;On 6/13/25 and 6. "Not Applicable"On 6/17/25 at 1:5 minutesFor the Walking Pr spent training and swere eight responseThere were no incorpogram had occur. 7. Interview on 6/17 regarding resident arevealed that she program every day extremity exercises. Interview on 6/17/2 in her room revealed *Had lived at the fa *Participated in the Monday, Wednesda *Stated the staff did restorative exercises. Review of resident *Her diagnoses inclimpairment (a stage more pronounced to severe as demential fatigue. *Her most recent and assessment with an of 6/4/25 indicated:	mount of minutes spent Motion (active)", there were /14/25 the responses were /9 p.m., the response of nine rogram "Amount of minutes skill practice in walking", there es of "Not Applicable". dications that the walking red in the past 30 days. //25 at 1:04 p.m. with RA E B's restorative program articipated in her restorative it was offered with upper 5 at 2:38 p.m. with resident 8 and she: cility for the past year. restorative program on ay, and Fridays. If a good job with the es and had no concerns. 8's EMR revealed: on 5/31/24. Ituded mild cognitive es of cognitive decline that is than normal aging, but not as a), repeated falls, and other Innual comprehensive MDS in assessment reference date	F 688	8	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		435105	B. WING _			C 06/18/2025	
	ROVIDER OR SUPPLIER	RE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1311 VANDER HORCK ST BRITTON, SD 57430		ZIP CODE	1 00/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)		
F 688	*A Restorative Prograstaff development RN upper body exercises times a week for the extimes a which indicated she extimpaired. *Her 6/48/25 care plangle -A problem area of "Into]: decreased ROM[extimobility." -A goal of, "I would likelevel of functioningInterventions of a "N REHAB/RESTORATI to upper body extremed Flexibility [and] Montimes per week." -Job positions responsand RNA. *Her 6/18/25 POC (pointstory for the past 30 restorative program in twenty-three days frought thad recorded resest "Amount of minutes and Motion (active)" that inconstruction of 10.5/22/25 at 1:36 pminutes. -On 5/30/25 at 1:59 p.1 "Resident Refused". -On 6/9/25 at 1:59 p.1 minutes.	impairment on both sides. Image: Am Referral Form signed by IC on 1/29/25 indicated as were recommended five resident. It is essment score was eleven, was cognitively moderately in indicated: impaired mobility R/T [related and] decreased bed in the tolerance of the tolerance	F	588			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3)	ODATE SURVEY COMPLETED	
		435105	B. WING _			C 06/18/2025	
	WHEATCREST HILLS HEALTHCARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 688 Continued From page 15 8. Interview on 6/17/25 at 1:04 p.m. with RA E regarding resident 9's restorative program revealed that she participated in her individualized restorative program with upper and lower extremity exercises, but was known to refuse to participate. Interview on 6/17/25 at 2:46 p.m. with resident 9 in her room revealed she: *Had lived at the facility for the past year and a half. *Participated in the restorative program every other day. *Stated she enjoyed her restorative program and working with RA E on her exercises. Review of resident 9's EMR revealed: *She was admitted on 12/4/23. *Her diagnoses included Alzheimer's disease with late onset (a progressive neurodegenerative disorder that gradually impairs memory, thinking, and reasoning skills) and cerebrovascular disease (a group of conditions that affect the blood vessels in the brain, disrupting blood flow and potentially leading to brain damage). *Her most recent quarterly MDS assessment with an assessment reference date of 3/25/25 indicated:		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 VANDER HORCK ST BRITTON, SD 57430		<u> </u>	06/18/2025	
PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 688	8. Interview on 6/17 regarding resident servealed that she pindividualized resto lower extremity exerefuse to participate. Interview on 6/17/2 in her room reveale *Had lived at the far half. *Participated in the other day. *Stated she enjoyed working with RA E of the Review of resident. *She was admitted. *Her diagnoses include onset (a progred disorder that gradula and reasoning skills disease (a group of blood vessels in the and potentially lead. *Her most recent quan assessment referindicated: -"Functional Limitat lower extremity with *A Restorative Progroup exercises we week for the resideA 5/16/25 note indidoes 1:1 [one-to-or	2/25 at 1:04 p.m. with RA E 2/3 restorative program articipated in her rative program with upper and rcises, but was known to 2. 5 at 2:46 p.m. with resident 9 d she: cility for the past year and a restorative program every d her restorative program and on her exercises. 2/3 EMR revealed: on 12/4/23. uded Alzheimer's disease with assive neurodegenerative ally impairs memory, thinking, and cerebrovascular conditions that affect the brain, disrupting blood flow ing to brain damage). uarterly MDS assessment with arence date of 3/25/25 ion in Range of Motion" for a impairment on one side. uram Referral Form signed by RN C on 4/17/25 indicated re recommended five times a nt. cated "Restorative CNA also e] exercises."	F 6	88			
	indicated: -"Functional Limitat lower extremity with *A Restorative Progstaff development F group exercises we week for the reside -A 5/16/25 note indidoes 1:1 [one-to-on *Her 4/15/25 BIMS	ion in Range of Motion" for impairment on one side. Iram Referral Form signed by RN C on 4/17/25 indicated re recommended five times a int. cated "Restorative CNA also					

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1311 VANDER HORCK ST BRITTON, SD 57430	06	6/18/2025
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 688	*Her 6/18/25 care pl -A problem area of " to]: decreased ROM decreased transfer s [activities of daily livi-A goal of "Resident function" -Interventions of a "NREHAB/RESTORAT Exercise group for 1 Flexibility [and] Mon-Job positions responsed and RNA. *Her 6/18/25 POC (phistory for the past 3 restorative program twenty-three days for that had recorded responses for the quippent providing Ranincluded:On 5/22/25 at 1:36 6/3/25 at 1:59 p.m., responses of five mi-The other nineteer Applicable[.]"No responses had refused. 9. Interview on 6/17/25 regarding resident 1 revealed that she parestorative program, and sit-to-stand train to refuse participation.	an indicated: Impaired mobility R/T [related [,] decreased bed mobility[,] skills[, and] decreased ADLS ng] ability." will maintain current level of NURSING TVE: ACTIVE ROM Program 5 min. Tue-Thurs [for] -Wed-Fri [for] Strengthening." consible for that included CNA coint of care) response do days for the above indicated there were com 5/20/25 through 6/17/25 testion "Amount of minutes age of Motion (active)" that p.m., 5/30/25 at 1:53 p.m., and 6/9/25 at 1:59 p.m. the nutes for each date and time. In days had responses of "Not indicated the resident had 25 at 1:04 p.m. with RA E O's restorative program inticipated in her individual which included exercises using, although she was known in. at 2:52 p.m. with resident 10	F 6	38		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		435105	B. WING		06/18/2025	
	ROVIDER OR SUPPLIER	ARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1311 VANDER HORCK ST BRITTON, SD 57430		1 00/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 688	exercise at nine o'cl	restorative program's group lock in the morning. with RAE on her exercises. 10's EMR revealed:	F 688	3		
	*Her diagnoses incl impairment and prir osteoarthritis. *Her most recent quan assessment referindicated: -No impairment in "lof Motion" for both was a week for the sit-to-stand training times a week for the sit-to-stand training times a week for the she's Her 5/8/25 BIMS a which indicated she she's Her 6/18/25 care problem area of stolling: decreased ROM A goal of "I would lilevel of functioning." Interventions of a "REHAB/RESTORA Sit-to-Stand trainingJob positions respand RNA. *Her 6/18/25 POC (history for the above past 30 days indicated ays from 5/20/25 trecorded responses	uded mild cognitive nary generalized uarterly MDS assessment with rence date of 5/8/25 Functional Limitation in Range upper and lower extremities. Iram Referral Form signed by RN C on 10/10/24 indicated was recommended three extresident. Issessment score was fifteen, was cognitively intact. Ian indicated: "Impaired mobility R/T [related d." ike to maintain my current " NURSING TIVE: Transfer Program				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		435105	B. WING		C 06/18/2025	
	HEATCREST HILLS HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 688 Continued From page 18 6/3/25 at 1:59 p.m., and 6/9/25 at 1:58 p.m. the responses of ten minutes for each date and timeThe other twenty days were responses of "Not Applicable[.]"No responses had indicated the resident had refused. 10. Interview on 6/17/25 at 3:07 p.m. with residen 11 in his room revealed he: *Had lived at the facility for the past several years. *Participated in the restorative program. Review of resident 11's EMR revealed: *He was admitted on 7/2/19. *His diagnoses included dementia and primary generalized osteoarthritis. *His most recent quarterly MDS assessment with an assessment reference date of 3/24/25 indicated: -"Functional Limitation in Range of Motion" for lower extremities with impairment on both sides. *A Restorative Program Referral Form signed on 12/6/23 indicated upper extremity exercises were recommended three times a week for the resident. *His 3/24/25 BIMS assessment score was thirteen, which indicated he was cognitively intact "His 6/18/25 care plan indicated: -A problem area of "Impaired mobility R/T [related of 1 means		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 VANDER HORCK ST BRITTON, SD 57430		06/18/2025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 688	6/3/25 at 1:59 p.m., responses of ten mThe other twenty of Applicable[.]"No responses had refused. 10. Interview on 6/11 in his room reverthad lived at the faryears. *Participated in the Review of resident *He was admitted of this diagnoses included an assessment referindicated: -"Functional Limitat lower extremities w *A Restorative Programmended three resident. *His 3/24/25 BIMS thirteen, which indicated: -"Functional Limitat lower extremities w *A Restorative Programmended three resident. *His 3/24/25 BIMS thirteen, which indicated: -"Functional Limitat lower extremities w *A Restorative Programmended three resident. *His 3/24/25 BIMS thirteen, which indicated: -"Functional Limitates and the second resident. *His 6/18/25 care p -A problem area of to]: decreased ROM and] decreased train-A goal of "I would I level of functioningInterventions of a "REHAB/RESTORA Exercise group for the second resident resident."	and 6/9/25 at 1:58 p.m. the inutes for each date and time. days were responses of "Not dindicated the resident had 17/25 at 3:07 p.m. with resident aled he: cility for the past several restorative program. 11's EMR revealed: on 7/2/19. uded dementia and primary rthritis. parterly MDS assessment with erence date of 3/24/25 gion in Range of Motion" for ith impairment on both sides. Gram Referral Form signed on pper extremity exercises were entimes a week for the assessment score was cated he was cognitively intact. Ilan indicated: "Impaired mobility R/T [related M[,] decreased bed mobility[, insfer skills." itke to maintain my current "	F 68			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		435105	B. WING	_		06/	18/2025
	ROVIDER OR SUPPLIER REST HILLS HEALTHCAI	RE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 311 VANDER HORCK ST BRITTON, SD 57430		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688	and RNA. *His 6/18/25 POC (pot for the past 30 days for program indicated the 5/20/25 through 6/17/ responses for the quespent providing Rangincluded: On 5/22/25 at 1:38 pminutes. On 5/30/25 at 1:53 pminutes. On 6/3/25, 6/9/25, at minutes. On 6/3/25, 6/9/25, at minutes. On 6/3/25, 6/9/25, at minutes. The other nine days Applicable[.]" 11. Interview on 6/17/ regarding resident 12 revealed that she par exercise restorative puse of TheraBands at extremity exercises. Review of resident 12 *She was admitted on *Her diagnoses included and history of falling. *Her most recent adminutes and 4/6/25 indicated: -No impairment in "Fund for both up *A Restorative Prografication of the form of the prografication of the form of the fo	pint of care) response history or the above restorative ere were fourteen days from (25 that had recorded estion "Amount of minutes e of Motion (active)" that o.m. the response of five o.m. the response of ten and 6/17/25 the responses of a had responses of "Not (25 at 1:04 p.m. with RAE is restorative program ticipated in the group program, which included the not upper and lower (25 EMR revealed: a 3/31/25. Ided dementia, weakness, mission comprehensive MDS assessment reference date and lower extremities. It is a signed on the story of the stor	F	688			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF D	20//055 05 01/05/155	435105	D. WING		TREET ADDRESS SITV STATE ZID SODE	06/	18/2025
	ROVIDER OR SUPPLIER	RE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 311 VANDER HORCK ST BRITTON, SD 57430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 688	to]: decreased ROM[, decreased transfer sk ambulation skills." -A goal of "The reside of functioning" -Interventions of a "N REHAB/RESTORATI' Exercise group for 15 Flexibility [and] Mon-\Job positions responded RNA. *Her 6/18/25 POC (pointstory for the past 30 restorative programs twenty-five days from that had recorded resiliant and 6/9/25 at 1:36 pand 6/9/25 at 1:36 pand 6/9/25 at 1:59 p.r. minutes. On 5/30/25 at 1:52 printing. The other twenty-on "Not Applicable[.]" 12. Interview on 6/17/ *At 11:53 a.m. she stally and the fally worked every other to CNA. Worked four days a verification of the restoration of the	n indicated: mpaired mobility R/T [related] decreased bed mobility[,] kills[, and] decreased ent will maintain current level URSING VE: ACTIVE ROM Program of min. Tue-Thurs [for] Wed-Fri [for] Strengthening." Insible for that included CNA Dint of care) response Of days for the above indicated there were Indicated there were Indicated there were Indicated the question pent providing Range of included: Inc. M., 6/3/25 at 1:59 p.m., In. the responses of fifteen Inc. M. the responses of ten Inc. May be a seek and a seek monday through included. Inc. M. the response of ten Inc. M. the	F	688			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		OATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 VANDER HORCK ST BRITTON, SD 57430		00/10/2023
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F 688	from restorative to a residents would not completed that day. *At 1:04 p.m. regard -Residents that work department were traprogram when their -Currently twelve resprogramShe conducted residents are conducted residents that work department were traprogram when their should be conducted residents are conducted residentsStaff development if the restorative programsRA E reviewed the	stration with getting moved floor CNA as that meant the get their restorative programs ing the restorative program: led with the therapy ensitioned to a restorative therapy ended. Sidents were on a restorative dent group and individual sidents. RN C set up and discussed ams with her. Restorative Program binder storative Program Referral	F 6	88		
	rehabilitation D reve- would transition to a their therapy ended. Interview on 6/17/25 administrator A rega Program policy and revealed those flows the EMR for each re Interview on 6/17/25 nursing (DON) B reg program revealed: *Staff development F MDS coordinator, intresponsible for the re programs. *Restorative program Friday and not on the	rding the Restorative the Restorative Flowsheets theets were electronic and in sident. at 4:13 p.m. with director of tarding the restorative RN C was also the provider's fection preventionist, and was tesidents' restorative as occurred Monday through				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1311 VANDER HORCK ST BRITTON, SD 57430	06	6/18/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 688	a bath aide; and a reweek. *She agreed that who CNA, the restorative work as a CNAShe agreed that had month of MayShe stated May was due to CNAs resigningShe confirmed that programs were not go to their care plans. Interview on 6/18/25 revealed: *She had worked at and had been trained provider's nurse aide to the bath aide was seriday and when CN the bath aide. *She confirmed CNA 2025) and that four the and were currently in the stated that if the working on the floor, would be reassiged to the floor. *If no restorative aide bath aide would get on the floorShe stated that RA restorative to the floot today (6/18/25) to woo the stated that the context of the floot today (6/18/25) to woo the stated that the context of the floot today (6/18/25) to woo the stated that the context of the floot today (6/18/25) to woo the context of the floot today (6/18/25) to woo the context of the context of the floot today (6/18/25) to woo the context of t	e for each of the three wings; storative aide four days a en the day shift was short a aide would be reassigned to doccurred on ten days in the a difficult month for staffing and or going on leave. The residents' restorative etting completed according at 9:43 a.m. with CNA F the facility for close to a year das a CNA through the training program. Scheduled Monday through A F worked she typically was as had quit last month (May to six CNAs had been hired a training. Here were only two CNAs then the restorative aide to work as a CNA on the exassigned to work as a CNA E had been pulled from on Monday and again	F 6	88		
	was reassigned to th	e floor to work as a CNA estorative programs were not				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION G	COMPLETED
		435105	B. WING		C
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1311 VANDER HORCK ST BRITTON, SD 57430		06/18/2025	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 688	Continued From pa	ge 23	F 68	8	
	development RN C *She had been resprestorative program *There were current restorative program *She expected the participate three to restorative program plan. *RA E was the main out the restorative program out the restorative ROM except CNA's trainingShe stated that the a group exercise and	oonsible for the residents' ns since October 2024. itly twelve residents on a			
	again at 1:15 p.m. I *Expressed frustrat the floor that mornin CNA. *Stated activities st exercise activity that *Recalled CNAs hat there were three or that had been hired program. *Agreed that most of five sessions of the the past 30 days du complete the restor been pulled to the fi *Stated "I'm tired of *Clarified that the "I	ion with being reassigned to ng (6/18/25) to work as a aff had conducted a group			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		435105	B. WING			C 6/18/2025	
NAME OF PROVIDER OR SUPPLIER WHEATCREST HILLS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1311 VANDER HORCK ST BRITTON, SD 57430	1 0	0/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 688	*She confirmed that programs were not gplanned. Interview on 6/18/25 restorative program which worked full-time on completed any restoresidents. *Agreed that RA E which work as a CNA frequiprograms were not distributed those days. Interview on 6/18/25 regarding the restorative worked full-time on completed anything in programs. *Encouraged the restorative program. *Agreed that the rest pulled to the floor to when RA E was wothe restorative program. Interview on 6/18/25 revealed she: *Was aware that RA on the floor as a CNA needed on the floor. *Confirmed May 202 one CNA had resigning one on leave. *Agreed that the active active program on leave. *Agreed that the active program on the storative program on leave.	rogramming those days. the residents' restorative etting completed as care with CNA G regarding the revealed she: the day shift and had not rative programs with the as reassigned to the floor to ently and restorative one for the residents on at 1:27 p.m. with CNA H ative program revealed she: the day shift and had not regarding the restorative idents to be as independent not aware of who was on a	F 68				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING	(X3) DATE SURVEY COMPLETED
435105 B. WING	06/18/2025
NAME OF PROVIDER OR SUPPLIER WHEATCREST HILLS HEALTHCARE CENTER STREET ADDRESS, CITY, STATE 1311 VANDER HORCK ST BRITTON, SD 57430	·
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE	LAN OF CORRECTION (X5) IVE ACTION SHOULD BE COMPLETION ED TO THE APPROPRIATE FICIENCY) (X5) COMPLETION DATE
F 688 Continued From page 25 F 688	
restorative aide, but stated the activity staff had not documented those exercise activities as restorative exercises. *Was not aware of the CNAs charting for the restorative programs. *Was aware the restorative programs were not getting done. *Was not aware that in the last thirty days, there had only been five times for some residents when they had completed a restorative program. Interview on 6/18/25 at 2:04 p.m. with staff development RN C revealed: *She was aware of RA E being pulled to the floor. *She was not aware that CNAs did not know or had not completed the restorative ROM programs with the residents. *She stated that none of the residents' MDS assessments had indicated they had experienced a decline in their ROM. *She confirmed that there was a potential for decline when the restorative programs were not being completed according to their individual needs and care plans. Interview on 6/18/25 at 2:15 p.m. with administrator A confirmed that the activities staff had not documented the activity group exercises in the individual residents' Restorative Flowsheets as restorative exercises. Review of the provider's March 2019 Restorative Program policy revealed: *Policy: -"The Restorative Program focuses on achieving and maintaining optimal physical, mental and psychological functioning of the resident to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		435105	B. WING			C	
NAME OF PROVIDER OR SUPPLIER WHEATCREST HILLS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP 1311 VANDER HORCK ST BRITTON, SD 57430	CODE	06/18/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 688	practicable functionin -"The Center provide promote the resident' to living as independe *Guidelines: "The foll appropriate for a rest -"Any resident discon that requires ongoing functional gains." -"Any resident at risk *Responsibility: "The (DNS) [DON] has ove restorative program." *Procedure: -"The DNS/designee of care-based on the of the resident with in goals and interventio -"Restorative service: Restorative Nursing A Nursing Assistants (C volunteers trained in Restorative Program supervision." -"Each restorative se	g." s Restorative Programs to s ability to adapt and adjust ently and safely as possible." owing residents may be orative program:" tinued from active therapy restorative to maintain their for declining in function." Director of Nursing Services erall responsibility for the develops a restorative plan evaluated restorative needs dividualized, measurable ins." s are provided by Assistants (RNA), Certified cNA), or other staff and restorative techniques. The is under nursing rvice is recorded on a et each time the program is	F	688			