STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 57625**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/17/25 through 11/20/25. Medicine Wheel Village was found not in compliance with the following requirement(s): F565, F609, F644, F657, F658, F700, F732, F761, F801, F808, F868, F880, and F881 with an Immediate Jeopardy violation at F812. On 11/19/25 at 11:25 a.m., Immediate Jeopardy (IJ) a F812 was identified related to the provider's failure to follow proper sanitation of dishes with the use of a three-compartment sink while the mechanical dishwasher was out of service. On 11/19/25 at 10:25 a.m. administrator A was notified verbally and in writing of the IF at F812. On 11/19/25 at 4:31 p.m., administrator A provided a final plan for the removal of the immediate jeopardy, and the removal plan was accepted with agreed-upon changes made by the provider. On 11/19/25 at 5:44 p.m., the immediacy was removed after onsite verification by the survey team. After the immediacy was removed the severity of noncompliance remained at a F. The resident census was 28. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/17/25 through 11/20/25. Areas surveyed included possible neglect reported at a resident council meeting that was not reported to the immediate supervisor. Medicine Wheel Village was found not in compliance with the following requirement: F609.	F0000	**Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.** F 609 Reporting of Alleged Violations Criteria 1: The allegation of neglect was reported to the survey team during the survey as instructed by the Survey Agency office on 11/17/2025. Criteria 2: Interviews were conducted with the resident council and all interviewable residents by the Activity staff, Director of Social Services, and Activity Coordinator, as completed on 11/17/25 and 11/21/2025, to determine if there were any unreported allegations of neglect. There were no allegations voiced by the residents. Criteria 3: All facility staff have received Inservice education on the facility Abuse/Neglect policy and regulatory requirements as completed on 12/22/25 by Administrator. This training included but was not limited to the need to report all allegations of abuse/neglect to the staff supervisor and/or Administrator immediately. Criteria 4: The QAPI audit tool for the monitoring of compliance with the facility abuse/neglect policy and regulatory requirements will be utilized monthly X 2 months and then quarterly thereafter under direction of the Administrator. Results of these QAPI audits will be reviewed in facility QAPI meetings quarterly	12/26/2025
F0565 SS = D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take	F0565		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deb Arbogast	Nursing Home Administrator	12/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

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F0565 SS = D	Continued from page 1 reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on the resident council meeting, resident council meeting minutes review, grievance logs review, observation, interview, record review, and policy review, the provider failed to respond to the resident concerns communicated at resident council meetings regarding nursing care being performed in public and loud televisions. Findings include: 1. A resident council meeting held on 11/19/25 at 2:12 p.m. revealed: *Residents voiced complaints that their concerns communicated during previous resident council meetings were not resolved, which included:	F0565	F 565 Resident/Family Group and Response Criteria 1: The facility has addressed the resident concerns related to loud televisions/radios and resident care tasks being completed in common areas as follows: -Inservice education has been completed with the licensed and non-licensed nursing staff on 12/22/25 on the need to provide care tasks including but not limited to hair care, injections, vital signs and clothing adjustment in the residents' rooms or in a private care area (i.e., shower room, etc.). This was provided by the DON and Administrator. -Staff and residents were interviewed on 12/18/25 by SW, RN, MDS Coordinator, to determine which residents utilized their television or radio at a volume that could disturb others. These residents were provided with headphones or amplifying devices to maintain volumes at appropriate levels that would not be disruptive to the living environment. The headphones/amplifying devices will be checked by the Administrator and DON monthly to make sure they are properly functioning Criteria 2: A resident council meeting was held on 12/22/25 by Activity Coordinator to determine if the resident concerns r/t care tasks in resident common areas and television/radio volumes were effectively addressed. Residents present at the meeting indicated that there were no further concerns. The Social Service Director also interviewed facility interview able residents (BIMS greater than 8) that did not attend the resident council meeting, to determine if the concerns had been effectively addressed, and there were no concerns voiced. Criteria 3: The Director of Social Services (DSS)and the Administrator have received Inservice education on the need to review the Grievance log weekly and the Resident Council meeting notes monthly to identify any resident concerns that need to be addressed. The education was completed by the facility consultant. The DSS is completing follow-up meetings with the department responsible for the resolution of the concerns to determine that appropriate interventions have been implemented. The DSS is then conducting interviews with the residents who voiced the concerns to determine whether they have been effectively resolved. Criteria 4: The QAPI audit tool for the monitoring of resident grievances including but not limited to use of the designated grievance form, compliance with the facility policy, and follow-up on grievance resolution will be utilized monthly X 2 months and then quarterly under the direction of the Director of Social Services and the Administrator. Results of these QAPI audits will be reviewed in the facility QAPI meetings quarterly..	12/26/2025

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F0565 SS = D	Continued from page 2 -Loud televisions at night -Staff taking residents' vital signs, giving insulin injections, combing residents' hair, and fixing residents' clothing in shared common areas. *Complaints were heard by staff, but there was no follow-through. *Resident 17 reported, "The loud televisions are so bothersome it makes me physically sick." 2. A review of the providers' July-November 2025 resident council meeting minutes revealed: *On July 22, 2025, residents had concerns about televisions and radios being on and loud all night. -A 7/22/25 Grievance Log did not list the loud televisions or radios being on all night. *On August 20, 2025, residents had concerns about residents' televisions and radios being on all night and being loud. -An 8/20/25 Grievance Log stated, "No problems/concerns. *On September 17th, 2025, residents had concerns with residents not being presentable for meals and not adjusting residents' clothing and brushing residents' hair in the dining room or at activities in front of other residents. -A 9/17/25 Grievance Log revealed the problem with residents not being presentable for meals had been resolved by explaining to the residents that other residents had the right to not have their hair combed. It did not address the adjustment of the resident's clothing and hair combing in front of others. *On November 12, 2025, residents had concerns about nursing care being performed in front of others and loud televisions at night. -The 11/12/25 Grievance Log was not completed by the provider yet, as the meeting was a week ago. 3. Interview on 11/20/25 at 10:29 a.m. with activity/social services staff D revealed: *She oversaw the resident council meetings.	F0565		

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F0565 SS = D	Continued from page 3 *She acknowledged that the resident's concerns about the loud televisions and not adjusting the resident's clothing or combing hair in front of others were not addressed on the grievance log. *When receiving a complaint, she would bring the complaint to the department head responsible for the area regarding the complaint, and the department head would talk to the resident who had the concern. *She stated that DON B addressed concerns about staff not administering shots or checking vital signs in the dining room and educated her staff. *She ordered headphones that hook up to the televisions that some residents were using, but some of those headphones were broken. 4. *Resident 2 who lived across from resident 17, who had the loud television at night, had not been offered headphones. *She talked with the staff about asking the residents, who wanted their televisions loud, to have their doors closed when their television was loud. 5. Observation and Interview on 11/20/25 at 7:48 a.m. with resident 23 in her room revealed: *Resident 2 had his door open, and the television was on at a loud volume. *Resident 17's room was across the hall from him, and her door was opened a crack. -Resident 2's television was heard from standing by her door. *Resident 23's room was diagonally across the hall from resident 2, and she reported difficulty sleeping due to the loud television volume at night. -Resident 2's television was heard from inside her room. 6. Interview on 11/20/25 at 7:55 a.m. with certified nursing assistant (CNA) R revealed: *In change of shift report that morning (11/20/25), it was brought up that resident 2's television was loud. *If staff were to ask him to turn his television down, she thought he would.	F0565		

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F0565 SS = D	Continued from page 4 *When asked if anyone had asked resident 2 to turn his television down that day, she replied "no". 7. Interview on 11/20/25 at 5:53 p.m. with director of nursing (DON) B revealed: *She had asked the caregiver staff to complete nursing care and medication administration in a private place. *She had an in-service scheduled for next week with the nursing staff regarding medication administration, checking vital signs, and adjusting residents' clothing and combing their hair in common areas. *She had observed nursing staff combing residents' hair, performing blood glucose checks, and administering medications in the dining room. 8. Interview on 11/20/25 at 4:10 p.m. with administrator A revealed: *Activity/social services D reported to her on 11/17/25 that a concern regarding providing nursing care in front of others was discussed at the 11/12/25 resident council meeting. *Resident council meeting grievance logs were reviewed with her, and she acknowledged that concern was brought up at the 9/17/25 meeting. *There were two to three residents who resided near resident 17's room who liked to have their televisions loud. *They purchased headphones and gave them to some of the residents. *She verified that providing resident care in the dining room and the loud television volume had not been addressed. 9. Review of resident 17's electronic medical record (EMR) revealed her 9/29/25 Brief Interview for Mental Status (BIMS) score was 15, which indicated her cognition was intact. 10. Review of resident 23's EMR revealed her 11/7/25 BIMS score was 11, which indicated her cognition was moderately impaired. 11. Review of the provider's 2001 Resident Council policy revealed: *" The purpose of the Resident Council is to provide a	F0565		

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F0565 SS = D	Continued from page 5 forum for: -Residents...to have input in the operation of the facility; -Discussion of concerns and suggestions for improvement...." *The facility department related to any issues will be responsible for addressing the item(s) of concern." 12. Review of the provider's 2001 Grievances/Complaints, Filing policy revealed: *" Residents...have the right to file grievances, either orally or in writing...." *" The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident...." *" The Grievance Office, Administrator and Staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated." 13. Review of the provider's 2001 Grievances/Complaints, Recording and Investigating policy revealed: *" All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). -Upon receiving a grievance and complaint report, the Grievance Officer will begin an investigation into the allegations. -The department director(s) of any named employee(s) will be notified of the nature of the complaint and that an investigation is underway." *" The 'Resident Grievance/Complaint Investigation Report Form' will be filed with the Administrator within five (5) working days of the incident." *" The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse, and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law."	F0565		
F0609	Reporting of Alleged Violations	F0609		

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F0609 SS = D	Continued from page 6 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on resident council minutes review, interview, and policy review, the provider failed to ensure one of one certified nursing assistant (CNA)/activity staff (Q) who documented allegations of neglect regarding residents' personal care reported by residents, during an 11/12/25 resident council meeting reported those allegation to the administrator according to the provider's policy which resulted in those allegations not being reported to the South Dakota Department of Health (SD DOH) in the required time frame of no more than 24 hours after the allegations were made. Findings include: 1. Review of the provider's 11/12/25 resident council meeting minutes revealed: *"Resident concerns/comments" included:	F0609	F 609 Reporting of Alleged Violations Criteria 1: The allegation of neglect was reported to the survey team during the survey as instructed by the Survey Agency office on 11/17/2025. Criteria 2: Interviews were conducted with the resident council and all interview able residents by the Activity staff, Director of Social Services, and Activity Coordinator, as completed on 11/17/25 and 11/21/2025, to determine if there were any unreported allegations of neglect. There were no allegations voiced by the residents. Criteria 3: All facility staff have received in service education on the facility Abuse/Neglect policy and regulatory requirements as completed on 12/22/25 by Administrator . This training included but was not limited to the need to report all allegations of abuse/neglect to the staff supervisor and/or Administrator immediately. Criteria 4: The QAPI audit tool for the monitoring of compliance with the facility abuse/neglect policy and regulatory requirements will be utilized monthly X 2 months and then quarterly thereafter under direction of the Administrator. Results of these QAPI audits will be reviewed in facility QAPI meetings quarterly.	12/26/2025

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F0609 SS = D	Continued from page 7 -"Nursing-Resident's concerns, with some resident[s] that can't comb their own hair and wash their own faces are sometimes messy at meals and activity time. Also, that some resident[s] have their legs or stomachs showing when they come into [the] dinning [dining] room for meal[s] and for activities. Some residents are also concerned with how staff are sometimes seem to [too] busy and sound upset when answering call light[s]." -"Residents brought up nursing cares being done during activity time or in front of other residents, they want vital signs [measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate] done in private." 2. Interview on 11/20/25 at 4:52 p.m. with administrator and A and Minimum Data Set (MDS) consultant I regarding the reporting of allegations of abuse and neglect to the South Dakota Department of Health (SD DOH) revealed: *Certified nursing assistant (CNA)/activity staff Q coordinated, attended, and wrote the minutes for the 11/12/25 resident council meeting. -She had recorded allegations of neglect made by residents and had not reported those allegations to her supervisor or the administrator. *Administrator A stated that CNA/activity staff Q should have notified administrator A immediately of those allegations. *Administrator A was notified of the allegations on 11/17/25. -That was 5 days after the allegations were made. *Social service/activity supervisor E reported those allegations to the SD DOH on 11/18/25. *The provider initiated an investigation for the allegation. 3. CNA/activity staff Q was not at the facility and not available for an interview throughout the survey. 4. Review of the provider's 2024 QAPI [Quality Assurance and Performance Improvement] Coordination of Abuse, Neglect and Exploitation policy revealed "The	F0609		

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F0609 SS = D	Continued from page 8 QAA [Quality Assessment and Assurance] committee will determine through a coordinated effort:" ... "Whether there is further need for systemic action such as:" ... "Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about." Review of the provider's 2016 Abuse Prevention Program policy revealed: *"Investigate and report any allegations of abuse within timeframes as required by federal requirements." *"Involve the resident council in monitoring and evaluating the facility's abuse prevention program." *Reporting: -"All alleged violations involving abuse, neglect, ... will be reported by the facility Administrator, or his or her designee, to the following persons or agencies:" --"The State licensing/certification agency responsible for surveying/licensing the facility". -"An alleged violation of abuse, neglect, ... will be reported immediately, but not later than:" --"Two (2) hours if the alleged violation involves abuse OR has resulted in bodily injury; or" --"Twenty-four (24) hours if the alleged violations does not involve abuse AND has not resulted in serious bodily injury." Review of the provider's 2017 Abuse Investigation and Reporting policy revealed "All reports of resident abuse, neglect, ... shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management." A review of the provider's 2001 Grievances/Complaints-Staff Responsibility policy revealed "Any alleged abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, must be reported to the administrator immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events	F0609		

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F0609 SS = D	Continued from page 9 that cause the allegation do not involve abuse and do not result in serious bodily injury." Review of the provider's 2001 Grievances/Complaints, Filing policy revealed "The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse, and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law."	F0609		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (2) diagnosed with schizophrenia (a chronic mental disorder that affects how a person thinks, feels, and behaves, causing a distorted sense of reality) had an accurate level I (1) Preadmission Screening and Resident Review (PASRR) evaluation after having been identified as having a possible serious mental illness. Findings include: 1. Review of resident 2's electronic medical record	F0644	F 644 Coordination of PASARR and Assessments Criteria 1: A new PASARR Level I was completed along with the indicated Level II PASARR and associated referral as completed by DSS on 11/24/25. Criteria 2 An audit was completed by DSS and Activity Coordinator on 11/19/25 to determine that all current residents have accurate PASARR screenings completed Criteria 3: The Activity/SS staff have received in service education by Administrator and/or Proactive Consultant as completed on 11/19/25 on the need to accurately complete PASARR screening on admission and with any new diagnosis of a mental health disorder. Criteria 4: The Activity/SS staff will audit PASARR screenings every six months to determine that they are accurately completed and Level II PASARRs and referrals have been completed as indicated. Audit Results will be reviewed at QAPI meetings on a monthly basis for four months and then quarterly for up to 12 months, for a total of one year.	12/26/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0644 SS = D	Continued from page 10 (EMR) revealed: *He admitted to the facility on 9/3/19. *He had an 8/21/25 Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. *He had a diagnosis of schizophrenia. *Resident 2's9/19/19 PASRR level II Pre-Admission Screening and Resident Review stated, "The diagnosis of mental illness is unsubstantiated [Resident 2's current diagnoses list did not contain a diagnosis that was considered a serious mental illness]". *There was a 6/22/25 physician's order for resident 2 to be given a one milligram (mg) tablet of Risperdal [a medication that alters the activity of neurotransmitters in the brain to reduce symptoms schizophrenia] by mouth three time a day. *Resident 2 did not have a current diagnosis of unspecified mood disorder. *Review of resident 2's 9/3/19 physician's progress note identified as the history and physical for admission to the facility revealed resident 2's diagnosis for unspecified mood disorder had a line through it and schizophrenia was written behind with the initials of medical director BB. *Review of diagnoses printed on 10/16/24 for resident 2 revealed the diagnosis of schizophrenia "PER 9/29/09 VST [visit]". 2. Interview on 11/18/25 at 8:30 a.m. with resident 2 revealed he: *Was diagnosed with schizophrenia about seven years ago. *Had been seeing a mental health provider. 3. Interview on 11/19/25 at 9:03 a.m. with South Dakota (SD) PASRR screening manager revealed: *The PASRR submitted in September 2019 was unsubstantiated because the diagnosis was unspecified mood disorder and that was not considered a serious mental illness. *The provider was not compliant with resident 2's PASRR requirements because they should have submitted a new	F0644		

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F0644 SS = D	Continued from page 11 PASRR when resident 2's diagnosis changed from unspecified mood disorder to schizophrenia upon admit on 9/3/19. 4. Interview on 11/20/25 at 10:19 a.m. with activity/social service staff (SS) D and SS/activity staff E revealed: *A referral for a level II PASRR evaluation and determination would need to be submitted for any resident with a new mental health diagnosis, a change in mental health diagnosis, or a new mental health medication to evaluate for a possible serious mental illness. *Activity/SS D was responsible for completing those referrals for level II PASRRs at the time resident 2 admitted to the facility. *Activity/SS D was unaware that resident 2's mental health diagnosis had changed during the admission process. *She stated the initial PASRR level I screening was completed with a diagnosis of unspecified mood disorder and the PASRR level I screening indicated the diagnosis of mental illness was unsubstantiated. *Activity/SS D had not submitted a referral for a level II PASRR evaluation and determination for resident 2 because she was not aware his diagnosis had changed from unspecified mood disorder to schizophrenia on 9/3/19. *Activity/SS staff D reviewed resident 2's 9/3/19 physician's note that was identified as his history and physical for admission and verified unspecified mood disorder was crossed out and changed to schizophrenia by medical director BB. 5. Review of the provider's September 2025 PASRR policy revealed: *"The PASRR process requires that all individuals applying to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have a SMI [serious mental illness] or ID/DD [intellectual disability/developmental disability]. This is called a 'Level I screen'. Those individuals who test positive at a Level I are then evaluated in depth, called a 'Level II' PASRR. The findings of this evaluation result in determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's	F0644		

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F0644 SS = D	Continued from page 12 plan of care." *"If the Screening Form fails to identify any criteria of the individual having SMI and/or ID/DD, then no additional action is required and the admission to the nursing facility is automatically approved. The admitting/receiving facility must obtain a copy of the completed negative pre-screening form and confirm that the form was appropriately completed before admitting any individual to a Medicaid certified facility." *"Ensure the Screening form is completed and accurate prior to every admission. -If a negative screen- ensure screening is completed accurately based on all the presenting medical records available for review and screening form is filed in the medical records."	F0644		
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team	F0657	F 657 Care Plan Timing and Revision Criteria 1: -The care plan for Resident #2 has been reviewed/revised to reflect their Dx. of Schizophrenia and associated medication/monitoring interventions. -Resident #8 has been assessed by their attending health practitioner with new orders for pain management. The care plan for Resident #8 has been reviewed/revised to address their current pain status and pain management interventions. -Resident #21 was assessed by their attending health practitioner with new orders to address their depression/anxiety status. The care plan for Resident #21 has been reviewed/revised to address their depression/anxiety status and management interventions. Criteria 2: The care plans for residents with the Dx of depression/anxiety; constant pain, and Schizophrenia were reviewed by the care plan IDT to determine that all indicated Dx. and interventions were addressed. Revisions were made as indicated. Criteria 3: The Care plan IDT has received inservice education by Proactive Consultant on 12/09/25 on the need to address all indicated resident Dx. including but not limited to: depression/anxiety, constant pain, and Schizophrenia along with the appropriate interventions when developing and updating the care plans. Criteria 4: The QAPI audit tool for the monitoring of complete and accurate development;/updating of the care plan will be utilized by the MDS Coordinator monthly X 2 months and then quarterly thereafter. The completed QAPI audits will be reviewed in the facility QAPI meetings quarterly to monitor compliance and any indicated action plans.	12/26/2025

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F0657 SS = E	Continued from page 13 after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the care plans were revised and individualized for one of one sampled resident (2) with schizophrenia, one of one sampled resident (8) who reported constant pain, and one of one sampled resident (21) who had a diagnosis of depression and anxiety and made statements of no longer wanting to live, to reflect their current needs. Findings include: 1. Observation and interview on 11/18/25 at 8:00 a.m. with resident 21 in her room revealed: *She was sitting in her wheelchair beside her bed with her head lowered towards her chest. *She stated she was tired of doing the same things, so she sleeps "all the time". *Resident 21 began to cry, and stated she did not want to live anymore. *She missed her children, and no one came to see her anymore. *She stated she had spoken to staff about not wanting to live anymore, and they reassured her and told her they were there to help her. *Resident 21 began to cry harder and stated she should just try to kill herself. Review of resident 21's EMR revealed: *She admitted to the facility on 7/22/25. *She had 10/31/25 Brief Interview of Mental Status (BIMS) assessment score of 8, which indicated her cognition was moderately impaired. *Her diagnosis included dementia (a group of symptoms affecting memory, thinking, and social abilities), anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and depression. *A 10/18/25 a progress note stated medical director BB	F0657		

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F0657 SS = E	Continued from page 14 was at the facility to see resident 21 and that resident 21 "has been feeling more sad and this writer informed [medical director BB] that [resident 21] had increased episodes of feeling sad and at times is tearful." *She had a 10/18/25 physician's order for "FLUoxetine HCL Oral Capsule 10 MG [milligram] (Fluoxetine HCl) Give 1 capsule by mouth one time a day related to ANXIETY DISORDER, UNSPECIFIED (F41.9); DEPRESSION, UNSPECIFIED (F32.A)". Review of resident 21's 11/20/25 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) revealed: *A focus area that indicated, "The resident has a dementia diagnosis with periods of forgetfulness and anxiety." -The goal for that focus area was, "The resident will be able to communicate basic needs on a daily basis through the review date." -The interventions identified for that area were, "Ask yes/no questions in order to determine the resident's needs" and "Cue, reorient and supervise as needed." *Another focus area stated, "[Resident 21] uses psychotropic medications r/t [related to] Diagnosis of Depression and Anxiety." -The goal for that focus area was, "Will remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension [low blood pressure], gait disturbance or cognitive/behavioral impairment through review date." -The interventions for that area were, "Administer PSYCHOTROPIC medication as ordered by physician" and "Consult with pharmacy, MD [medical doctor] to consider dosage reduction when clinically appropriate at least quarterly." *Her care plan did not identify her depression and anxiety symptoms such as her tearfulness or statements of no longer wanting to live. *Her care plan did not address any potential triggers of her depression or anxiety. *Her care plan did not identify any nonpharmacological interventions to help her if she complained of or displayed symptoms of anxiety and depression.	F0657		

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F0657 SS = E	Continued from page 15 2. Observation and interview on 11/18/25 at 8:30 a.m. with resident 2 revealed he: *Was diagnosed with schizophrenia about seven years ago. *Had been seeing a mental health provider for his schizophrenia. Review of resident 2's electronic medical record (EMR) revealed: *He admitted to the facility on 9/3/19. *He had a BIMS assessment score of 15, which indicated his cognition was intact. *He had a diagnosis of schizophrenia. *He had a 6/22/25 physician's order for "RisperDAL Tablet 1 MG [milligram] (risperidone) [a medication that alters the activity of neurotransmitters in the brain to reduce symptoms of psychosis, a state of losing touch with reality] Give 1 mg by mouth three time a day every Mon [Monday], Wed [Wednesday], Fri [Friday] for Unspecified Mood Disorder." *He had a 6/22/25 physician's order for "RisperDAL Tablet 1 MG [milligram] (risperidone) Give 1 mg by mouth three time a day every Tue [Tuesday], Thu [Thursday], Sat [Saturday], Sun [Sunday] for Unspecified Mood Disorder." *A progress note on 8/12/25 at 10:55 a.m. stated, "Writer entered resident's room and attempted to talk with [the] resident as he is refusing to shower. Resident turned the other way from writer and when writer touched resident's shoulder resident shrugged away from writer. Writer attempted to communicate with resident and resident laid on [his] right side [and] faced the wall with [his] eyes closed." *A progress note on 8/12/25 at 11:05 a.m. stated, "It was reported to this writer that [resident 2] has become more resistant to doing things for himself and wants staff to do everything for him that he is fully capable to do for himself to keep him as independent with some area's [areas] in caring for himself. This writer did talk with [medical director BB] and received a verbal [order] to schedule a Psych [psychiatric] evaluation through [name redacted] Tele-Health. This writer updated his nurse today, LPN to schedule the appointment."	F0657		

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F0657 SS = E	Continued from page 16 *The 9/3/25 behavioral health progress note stated, -"He has a history of schizophrenia with hallucinations [to see, hear, smell, taste, or touch something that is not there]. Currently not having any auditory hallucinations and he reports last occurrence was in the 90s." -"He has been on Risperdal for many years and was hospitalized in 1998 due to hallucinations." -"Document all behaviors and nonpharmacological interventions in the EMR." -"Monitor resident for daytime somnolence [excessive sleepiness or drowsiness], worsening of ambulation or falls, return of hallucinations, and notify provider with any concerns." *The 10/28/25 behavioral health progress note stated, "Patient [resident 2] did not appear for scheduled appointment" and identified the same plans of care as the 9/3/25 behavioral health progress note. Review of resident 2's 11/20/25 care plan revealed: *A focus area that stated, "[Resident 2] used smokeless tobacco. [Resident 2] and his family feel tobacco helps with his Schizophrenia symptoms." *A focus area that stated, "[Resident 2] uses psychotropic medications r/t Schizophrenia Diagnosis." -The goal for that focus area was, "[Resident 2 will remain free from psychotropic drug related complications through review date." -The interventions identified were, "Administer PSYCHOTROPIC medications as ordered by physician"; "Consult with pharmacy, MD to consider dose reduction when clinically appropriate with appropriate documentation"; Discuss with MD, family re [regarding] ongoing use of medications. Review behaviors/interventions and alternate therapies attempted and their effectiveness as needed with care conferences & [and] MD visits" and "Monitor/document/report PRN and adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person."	F0657		

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F0657 SS = E	Continued from page 17 *Resident 2's care plan did not identify his behaviors or symptoms of schizophrenia or interventions to attempt if his exhibited behaviors or symptoms of schizophrenia. *It did not address his displayed refusal to care for himself and participate in his activities of daily living, such as showering and interventions for this or any interventions that 3.had been attempted and failed. *It did not indicate he was seeing a mental health provider for his symptoms or behaviors. *There were no nonpharmacological interventions for his behaviors or symptoms to help him if or when they may occur. 3. Review of resident 8's 9/12/25 comprehensive Minimum Data Set submission section J revealed: *Resident 8 had a scheduled pain medication regimen, had received PRN [as needed] pain medications or was offered and declined, did not receive non-medication interventions for pain. *Resident 8 had pain or hurting in the last five days, she indicated the pain was experienced almost constantly, and in the past five days pain had made it hard for resident 8 to sleep almost constantly. Review of resident 8' EMR revealed: *She admitted to the facility on 2/19/19. *She had a 9/4/25 BIMS assessment score of 11, which indicated her cognition was moderately impaired. *Her diagnoses included, pain in her foot and diabetic neuropathy (nerve damage caused by diabetes, most often affecting the feet and legs, and is characterized by symptoms like numbness, tingling, burning, or sharp pains). *She had a 10/22/19 physician's order for "Tylenol Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for pain to feet bilat [both feet]". *She had a 3/11/20 physician's order for "Muscle Rub PRN every 8 hours to feet." *She had a 10/5/21 physician's order for "Acetaminophen Tablet 325 MG Give 2 tablet by mouth one time a day for	F0657		

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F0657 SS = E	Continued from page 18 Pain". *She had a 4/14/23 physician's order for "Muscle Rub apply to both feet topically at bedtime." *She had a 2/27/25 physician's order for "Gabapentin Capsule 300 MG Give 2 capsule by mouth at bedtime for Foot pain." *She had a 5/23/25 physician's order for "Gabapentin Capsule 300 MG [a medication used to treat nerve pain] Give 1 capsule by mouth two times a day for Foot pain. Review of resident 8's 11/19/25 care plan revealed she did not have a focus area goal or any identified pharmacological (medication) or nonpharmacological interventions identified for her pain. 4. Interview on 11/20/25 at 12:13 with licensed practical nurse (LPN) O revealed: *If she had a question related to a resident's care needs, she would reference the resident's care plan. *LPN O stated she did not know what resident 2's schizophrenia symptoms were because she had not witnessed him having any symptoms. *She stated she would not know what resident 2's schizophrenia symptoms were, to monitor for them, if they were not identified on his care plan. *She expected the behaviors identified on the care plan to have interventions for those behaviors. *She expected nonpharmacological interventions to treat a resident's pain to be identified on the resident's care plan. *She was unsure who was currently responsible to update resident care plans, but the MDS nurse used to be responsible. 5. Interview on 11/20/25 at 4:32 p.m. with administrator A and MDS consultant I revealed: *It was the responsibility of the MDS coordinator to update residents' care plans. *Care plans were to include a resident' behaviors, and triggers for identified behaviors being treated with pharmacological interventions and non-pharmacological interventions for those behaviors.	F0657		

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F0657 SS = E	Continued from page 19 *MDS consultant I stated pain should be a part of every resident's care plan especially those with identified acute or chronic pain. -The resident's pain care plan should include nonpharmacological intervention specific to that resident. *Resident 2's symptoms of schizophrenia were expected to be identified in his care plan so staff would be able to monitor for those symptoms and the effectiveness of his treatment, and interventions identified for those symptoms. *They expected pain to be identified in resident 8's care plan and include nonpharmacological interventions to manage her pain. *MDS consultant I verified resident 21's care plan had not been updated to include the symptoms or behaviors resident 21 had or identify the target symptoms. 6. Interview on 11/20/25 at 5:38 p.m. with director of nursing (DON) B revealed: *Resident 21 struggled with sadness and depression since she admitted to the facility. *When she was admitted she often refused to leave her room. *Her anti-depressant medication was changed from sertraline to fluoxetine because she had become more tearful. *DON B did not know if her not leaving her room, tearfulness, or expression so of not wanting to live any longer had been included in resident 21's care plan. Review of the provider's 8/21/24 Comprehensive Care Plans policy revealed: *"It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." *"The comprehensive care plan will describe, at minimum the following:	F0657		

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F0657 SS = E	Continued from page 20 a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being... f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated." *"The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objective will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed."	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to follow professional standards to ensure the effectiveness and adverse reactions of an antidepressant medication were documented for one of one sampled resident (21) with a newly ordered antidepressant medication (fluoxetine) for anxiety and depression. Findings include: 1. Periodic observations on 11/17/25 between 1:34 p.m. and 3:53 p.m. of resident 21 revealed each time she was visualized in her room she was resting on her back in her recliner, with her eyes closed, and her feet elevated. 2. Observation and interview on 11/18/25 at 8:00 a.m. with resident 21 in her room revealed: *She was sitting in her wheelchair beside her bed with her head lowered towards her chest. *She stated she was tired of doing the same things, so she sleeps "all the time". *Resident 21 began to cry, and stated she did not want	F0658	F 658 Services Provided Meet Professional Standards Criteria 1: Resident #21 was assessed by their attending health practitioner with new orders to address their depression/anxiety status. The care plan for Resident #21 has been reviewed/revised to address their depression/anxiety status and management interventions along with the medication side effect monitoring in place. Criteria 2: Residents with the Dx of depression/anxiety have been reviewed by the DON and MDS Coordinator on 12/22/25 to determine that side effect monitoring is in place and that there are no current adverse reactions with effectiveness of their ordered medications. Criteria 3: The licensed nurses have received inservice education by the DON and the Administrator on the need to complete monitoring/documentation for side effects and effectiveness of ordered psychotropic medications as completed on 12/22/25. Criteria 4: The QAPI audit for psychotropic medication use, including monitoring/documentation of and side effects and effectiveness, will be utilized by the DON monthly X 2 months and then quarterly thereafter. The completed QAPI audits will be reviewed in the facility QAPI meetings quarterly.	12/26/2025

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F0658 SS = D	Continued from page 21 to live anymore. *She missed her children, and no one came to see her anymore. *She stated she had spoken to staff about not wanting to live anymore, and they reassured her and told her they were there to help her. *Resident 21 began to cry harder and stated she should just try to kill herself. 3. Observation on 11/18/25 at 9:52 a.m. of resident 21 beside the 300 hallway nurses station revealed she was in her wheelchair with her chin on her chest, and her eyes closed. 4. Review of resident 21's electronic medical record revealed: *She admitted to the facility on 7/22/25. *She had 10/31/25 Brief Interview of Mental Status (BIMS) assessment score of 8, which indicated her cognition was moderately impaired. *Her diagnosis included dementia (a group of symptoms affecting memory, thinking, and social abilities), anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and depression. *She had a 10/18/25 physician's order for "FLUoxetine HCL Oral Capsule 10 MG [milligram] (Fluoxetine HCl) Give 1 capsule by mouth one time a day related to ANXIETY DISORDER, UNSPECIFIED (F41.9); DEPRESSION, UNSPECIFIED (F32.A)". *Resident 21's 11/20/25 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had focus areas that stated: -"The resident has a dementia diagnosis with periods of forgetfulness and anxiety." -"[Resident 21] uses psychotropic medications r/t [related to] Diagnosis of Depression and Anxiety." *Review of resident 21's progress notes revealed one entry after the initiation of the fluoxetine on 10/20/25 which stated, "Resident started on Prozac [fluoxetine] 10mg on 10/21/25. Resident pleasant and cooperative. No behaviors noted this shift."	F0658		

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F0658 SS = D	Continued from page 22 5. Interview on 11/20/25 at 12:05 p.m. with licensed practical nurse (LPN) O revealed: *When a resident had new orders for medication such as an antibiotic or antidepressant the resident's name and the medication name were placed on a hot charting form, which would prompt the nursing staff to document symptoms and/or adverse reactions of the medication on each shift. *The nursing staff were responsible for monitoring and documenting adverse reactions and the effectiveness of the medication. *She was not sure how long they were to document about an antidepressant after they were started, but antibiotics documentation was to be completed each shift for the first 72 hours after the start of the antibiotic. 6. Review of the provider's hot charting forms for October 2025 revealed: *An area labeled medication changes/monitoring and a location to write the resident's name, medication, start date, and end date. *Instructions on the bottom of the medication changes/monitoring area stated: -"*Antipsychotic meds [medications]- ADRs [adverse drug reactions] need [to be] charted x [times] 3 days." -"*Antihypertensive, cardiac, diuretics, etc. -System specific vitals [vital signs], ADRs, & [and] edema need to be charted on x 3 days." -"*Discontinues or decreased dose of medication need to be". *On 10/20/25 the hot charting form included "[resident 21] – fluoxetine 10mg" *On 10/21/25, 10/22/25, and 10/23/25 the hot charting form included "[resident 21] Prozac (fluoxetine) 10mg" 7. Interview on 11/20/25 at 4:32 p.m. with administrator A and Minimum Data Set (MDS) consultant I revealed: *Administrator A expected newly ordered psychotropic meds to be reviewed at the time a new order was received.	F0658		

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F0658 SS = D	Continued from page 23 *The newly ordered psychotropic medications should then be added to the provider's hot charting form to prompt the nursing staff to monitor and document any adverse effects and the effectiveness of the medication for each shift for the first 72 hours. *The social services personnel were expected to document the effectiveness of behavior management related to a resident's newly ordered psychotropic medication. *Administrator A and MDS consultant I verified there was only one progress note entered by nursing for resident 21 in the first 72 hours after she was started on fluoxetine and there was no documentation by the social service personnel related to on the effectiveness of the fluoxetine in resident 21's first month of use. 8. Interview on 11/20/25 at 5:38 p.m. with director of nursing (DON) B revealed: *Resident 21 struggled with sadness and depression since she admitted to the facility. *When she was admitted she often refused to leave her room. *Her anti-depressant medication was changed from sertraline to fluoxetine because she had become more tearful. *DON B was not aware resident 21 had reported her feelings of wanting to die to staff and verified this had not been documented in resident 21's EMR. *DON B verified there was no consistent documentation of resident 21 symptoms of tearfulness prior to the change in medication from sertraline to fluoxetine and there was only one nurse progress note after the fluoxetine was started. *She agreed there was not a resident complaint, symptom or behavior identified as the intended use for Prozac. *DON B agreed resident 21's symptoms had not been documented, so she was not able to determine if the fluoxetine was helping with resident 21's tearfulness. *DON B verified adverse reactions were not being monitored or documented on resident 21's TAR as other residents on psychotropic medications were.	F0658		

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F0658 SS = D	Continued from page 24 Review of the provider's undated Psychotropic Medication Policy and Procedure policy revealed: *"The purpose of the Psychotropic Drugs Policy and Procedure is to develop a facility system to ensure a resident is not given psychotropic medications unless a comprehensive assessment identifies clear indications and parameters for use, based upon regulatory compliance and best practice. In addition, the facility will manage and monitor the resident's medication regimen, identify the need for gradual dose reductions, use of non-pharmacological interventions in an effort to decrease or discontinue psychotropic drugs and limit PRN [as needed] orders to be used only when necessary, consistent with regulatory compliance, to maintain or promote the highest level of resident function and quality of care." *"A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic". *"Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that- Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in effort to discontinue these drugs;" *"A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being."	F0658		
F0700 SS = E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails.	F0700	F 700 Bedrails Criteria 1: -Residents 1, 2, 3, 7, 8, 14, 15, 17, and 20 have been assessed for the need for assist rails/enablers with risk/benefit analysis by the Care Plan IDT on 12/22/25	12/26/2025

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F0700 SS = E	Continued from page 25 The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure ten of ten sampled residents (1, 2, 3, 7, 8, 14, 15, 17, and 20) who used side rails on their bed had alternatives attempted prior to the implementation of those side rails and four of ten sampled residents (3, 7, 8, and 17) with side rail son their beds were assessed for safe use of those rails within the last three months according to the provider's policy. Findings include: 1. Observation on 11/17/25 at 1:23 p.m. of resident 15's room revealed two quarter-length side rails in the up position at the head of her bed. Interview on 11/18/25 at 8:46 a.m. with resident 15 in her room revealed she: *Used both side rails to get out of bed, depending on which side of the bed she was getting out of. *Was provided education on the risks versus benefits of the side rails when she admitted to the facility. Review of resident 15's EMR revealed she:	F0700	The residents that did not require the device to assist with bed mobility and transfers or who's risks exceeded the benefits have had alternative interventions implemented and addressed on the their care plan -Residents 3, 7, 8, and 17 have had completion of a new siderail assessment with risk/benefit analysis as completed on 12/22/25 by DON and MDS Coordinator. Any changes in siderail use determined by the new assessment was implemented and addressed on the care plan. Criteria 2: The siderail assessment for all other current in-house residents have been reviewed/updated with risk/benefit analysis to determine if they require an assist rail/enabler for bed mobility and transfers. Those that did not require the device to assist with bed mobility and transfers or who's risks exceeded the benefits have had alternative interventions implemented and addressed on the their care plan. Criteria 3: The licensed nurses have received inservice education by DON as completed on 12/26/2025 on the siderail assessment process which included but was not limited to: accurate completion of the siderail assessments with risk/benefit analysis quarterly and with any change in the resident's condition; determination of interventions based on the risk/benefit analysis and resident need for an assistive device, and the need to update the care plan with any device changes. Criteria 4: The QAPI audit tool for the monitoring of siderail use will be utilized under the direction of the DON monthly X 2 months and then quarterly thereafter. The completed QAPI audits will be reviewed in the quarterly QAPI meetings to monitor compliance and any indicated action plans	

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F0700 SS = E	Continued from page 26 *Was admitted on 7/29/25. *Had a 11/4/25 Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact. *Had a 7/29/25 physician's order, "All residents of MWV [facility name] NH [Nursing Home] may have Positioning/Assist Bars [side rails] if indicated after Safety Assessment, Device Assessment and IDT [intradisciplinary team] review." *Had a 7/31/25 Positioning/Assist bar- Safety Assessment which indicated the symptoms that contributed to her need for the device [side rails] were cognitive impairment and a history of falls. -The check box in front of the "Risk of using side rails in bed include: Accident hazard (falls, entrapment, injuries); Barrier from safely getting out of bed; Physical restraint (hinders independence getting out of bed); Decline in function, such as muscle functioning/balance; Skin integrity issues; Decline in other areas of daily living, such as using the bathroom, continence, eating, hydration, walking, and mobility; Negative psychosocial outcomes, such as altered self-esteem, feelings of isolation, or agitation/anxiety" section was not checked. -The check box in front of the "My signature below specifies that I have discussed and reviewed the following items and was given the opportunity to ask questions and state my preferences in these aspects of my care" section was not checked. -The assessment did not include if any alternatives were attempted prior to the implementation of the side rails. -The form was signed on 7/31/25 by resident 15. 2. Observation on 11/17/25 at 1:55 p.m. of resident 2's room revealed two quarter-length side rails in the up position at the head of his bed. Interview on 11/18/25 at 8:30 a.m. with resident 2 in his room revealed: *He used the side rails to get in and out of his bed. *He was provided information on the risks and benefits of the side rails. Review of resident 2's EMR revealed:	F0700		

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F0700 SS = E	Continued from page 27 *He was admitted on 9/3/19. *He had an 8/21/25 BIMS assessment score of 15, which indicated his cognition was intact. *Had a 3/24/20 physician's order, "All residents of MWV [facility] NH may have Positioning/Assist Bars if indicated after Safety Assessment, Device Assessment and IDT review." *Had an 8/21/25 Positioning/Assist bar- Safety Assessment which indicated the symptoms that contributed to his need for the device were cognitive impairment, contracture/fracture and a history of falls. -The check box in front of the "Risk of using side rails" in bed section was not checked. -The check box in front of the "My signature" section was not checked. -The assessment did not include if any alternatives were attempted prior to the implementation of the side rails. -The form was signed on 8/21/25 by resident 2. 3. Observation and interview on 11/17/25 at 3:08 p.m. of resident 3 in her room revealed quarter bed rails attached to the sides of her bed, and they were in the up position. Resident 3 did not answer whether she used the side rails. Review of resident 3's EMR revealed she was admitted on 5/15/19. Her 10/21/25 BIMS assessment score was an 8, which indicated her cognition was moderately impaired. *A 6/18/25 nurses progress note indicated "resident [3] was very agitated ... resident was uncooperative with dressing. CNA reports sitting resident's bed up in fowlers position to put on a sweatshirt and resident put her arm through the siderail and hung on. CNA was able to get residents arm free from rail by laying the bed flat. Resident is now calm, dressed, and in bed watching TV [television]." *A 7/1/25 Positioning/Assist bar- Safety Assessment forms signed by resident 3 on 7/1/25 indicated: -The check box in front of the "Risk of using side rails" in the bed section was not checked.	F0700		

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F0700 SS = E	Continued from page 28 -The check box in front of the "My signature" section was not checked. -The assessment did not include if any alternatives were attempted prior to the implementation of the side rails. *There were no other documented side rail assessments completed after 7/1/25. 4. Observation on 11/17/25 at 3:14 p.m. of resident 8's room revealed two quarter-length side rails in the up position at the head of her bed. Review of resident 8's EMR revealed she: *Was admitted on 2/19/29. *Had a 9/4/25 BIMS assessment score of 11, which indicated her cognition was moderately impaired. *Had a 3/24/20 physician's order, "All residents of MWV NH may have Positioning/Assist Bars if indicated after Safety Assessment, Device Assessment and IDT review." *Had a 6/3/25 Positioning/Assist bar- Safety Assessment which indicated the symptoms that contributed to the need for the device were dementia (a group of symptoms affecting memory, thinking, and social abilities), a history of falls, Neurological disorder-seizures, and visual impairment- glaucoma (a groups of eye diseases which can lead to visions loss and blindness). -The check box in front of the "Risk of using side rails" section was not checked. -The check box in front of the "My signature" section was not checked. -The assessment did not include if any alternatives were attempted prior to the implementation of the side rails. -The form was signed on 6/3/25 by resident 8. *There were no other documented side rail assessments completed after 6/3/25. 5. Observation on 11/17/2025 at 3:15 p.m. of resident 7's room revealed a fall mat on the floor next to the bed, quarter-length side rails attached to the sides of her bed in the up position. Review of resident 7's EMR revealed she was admitted on	F0700		

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F0700 SS = E	Continued from page 29 3/11/20. Her 11/11/25 BIMS assessment score was a 4, which indicated her cognition was severely impaired. *A 7/9/25 Positioning/Assist bar- Safety Assessment forms signed by resident 7 on 7/9/25 and her guardian on 8/6/25 indicated: -The check box in front of the "Risk of using side rails" section was not checked. -The check box in front of "My signature" was not checked. -The assessment did not include if any alternatives were attempted prior to the implementation of the side rails. *There were no other documented side rail assessments completed after 7/9/25. 6. Observation on 11/17/25 at 3:21 p.m. of resident 1's room revealed quarter- length side rails attached to the sides of her bed in the up position. Review of resident 1's EMR revealed she was admitted on 6/9/22. Her 9/12/25 BIMS assessment score was a 15, which indicated her cognition was intact. *An 8/26/25 Positioning/Assist bar- Safety Assessment forms signed by resident 1 on 8/26/25 indicated: -The check box in front of "Risk of using side rails" section was not checked. -The check box in front of "My signature" was not checked. -The assessment did not include if any alternatives were attempted prior to the implementation of the side rails. 7. Observation and interview on 11/18/25 at 9:00 a.m. with resident 14 in her room revealed she: *Had one quarter-length side rail in the up position at the right side of the head of her bed. *Used the side rail to sit up in bed and transfer to and from her wheelchair. *Did not recall being provided education on the risks versus benefits of the side rail. *Did not recall being asked to give consent for the	F0700		

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F0700 SS = E	Continued from page 30 side rail to be attached to her bed. Review of resident 14's EMR revealed she: *Was admitted on 11/9/23. *Had a 11/5/25 BIMS assessment score of 15, which indicated her cognition was intact. *Had a 11/9/23 physician's order, "All residents of MWV NH may have Positioning/Assist Bars if indicated after Safety Assessment, Device Assessment and IDT review." *Had an 8/5/25 Positioning/Assist bar- Safety Assessment which indicated the symptoms that contributed to the need for the device were arthritis, a history of falls, cognitive impairment, contracture/fracture, and visual impairment. -The assessment indicated resident 14 had two side rails on her bed. -The check box in front of the "Risk of using side rails" was not checked. -The check box in front of the "My signature" section was not checked. -The assessment did not include if any alternatives were attempted prior to the implementation of the side rails. -The form was signed on 8/5/25 by resident 14. 8. Observation and interview on 11/18/25 at 9:33 a.m. with resident 17 in her room revealed she: *Had two quarter-length side rails in the up position at the head of her bed. *Used the side rails to get in and out of bed. *Was provided education on the risks and benefits of the side rails when she admitted but had not received any education about them since that time. Review of resident 17's EMR revealed she: *Was admitted on 3/18/25. *Had a 9/29/25 BIMS assessment score of 15, which indicated her cognition was intact. *Had a 3/18/25 physician's order, "All residents of MWV	F0700		

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F0700 SS = E	Continued from page 31 NH may have Positioning/Assist Bars if indicated after Safety Assessment, Device Assessment and IDT review." *Had a 6/3/25 Positioning/Assist bar- Safety Assessment which indicated the symptoms that contributed to the need for the device were arthritis, history of falls, and dizziness- sometimes. -The check box in front of the "Risk of using side rails" section was not checked. -The check box in front of the "My signature" section was not checked. -The assessment did not include if any alternatives were attempted prior to the implementation of the side rails. -The form was signed on 6/3/25 by resident 17. *There were no other documented side rail assessments completed after 6/3/25. 9. Observation and interview on 11/18/25 at 9:23 a.m. with resident 20 in his room revealed he: *Had two quarter-length side rails in the up position at the head of his bed. *Used the side rails on his bed to sit up when he was in bed. *Did not remember receiving any education related to the risks and benefits of the side rails. *Did not recall being asked to give consent for the side rails to be placed on his bed. *Stated the side rail on the left side of his bed was already on the bed when he admitted to the nursing home, and he asked for the second bed rail to be installed. Review of resident 20's EMR revealed he: *Was admitted on 6/5/25. *Had an 8/28/25 BIMS assessment score of 14, which indicated his cognition was intact. *Had an 8/13/25 physician's order, "All residents of MWV NH may have Positioning/Assist Bars if indicated after Safety Assessment, Device Assessment and IDT review."	F0700		

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F0700 SS = E	Continued from page 32 *Had an 8/26/25 Positioning/Assist bar- Safety Assessment which indicated the symptoms that contributed to the need for the device were history of falls, weakness, and dizziness. -The check box in front of the "Risk of using side rails" section was not checked. -The check box in front of the "My signature" section was not checked. -The assessment did not include if any alternatives were attempted prior to the implementation of the side rails. -The form was signed on 8/26/25 by resident 20. 10. Interview on 11/20/25 at 9:20 a.m. with director of nursing (DON) B revealed: *Side rail assessments were to be completed on all residents upon admission to the nursing home. *During quarterly care conferences the side rail assessment, the risks versus benefits of the side rails, and the consent were to be reviewed with each resident. *Alternatives to the side rails were not attempted prior to the installation of the side rails. *She verified the Positioning/Assist bar- Safety Assessment for residents 3, 7, 8, and 17 were not completed quarterly. xx. Interview on 11/20/25 at 4:32 p.m. with administrator A revealed: *She verified the side rail assessments that were provided were the most recent assessments in each resident EMR. *She was aware that some of the resident's side rail assessments were not completed quarterly. Review of the provider's 11/20/25 Rail Safety Audit instructions revealed: *"Nursing works with the Resident's Doctor and Family members to determine if the rails are necessary." *"All attempts should be made, and documented, by nursing to show that rails are necessary, if all other	F0700		

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F0700 SS = E	Continued from page 33 alternatives failed to assist the Resident." 12. Review of the providers October 2025 Proper Use of Bed Rails policy revealed: *"The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs." *"Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion." *"The information that the facility should provide to the resident, or resident representative includes, but is not limited to: a. What assessed medical needs would be addressed by the use of a bed rails; b. The resident's benefit from the use of bed rails and the likelihood of these benefits; c. The resident's risk from the use of bed rails and how these risks will be mitigated; and d. Alternatives attempted that failed to meet the resident's needs and alternatives considered but not attempted because they were considered to be inappropriate." *"Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptoms, or functional reason for the use of the bed rail." *"If no appropriate alternatives are identified, the medical record should include evidence of the following: a. Purpose for which the bed rail was intended and evidence that alternatives were tried and were not successful b. Assessment of the resident, the bed, the mattress, and rail for entrapment risk (which would include ensuring bed dimensions are appropriate for the resident size/weight), and	F0700		

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F0700 SS = E	Continued from page 34 c. Risk and benefits were reviewed with the resident or resident representative, and informed consent was given before installation or use."	F0700		
F0732 SS = F	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information daily: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The	F0732	F 732 Posted Nurse Staffing Information Criteria 1: The charge nurse will post the required daily nursing staffing information in a location readily visible to residents, staff, and visitors, that clearly reflected actual hours worked by the nursing staff, utilizing a template form that can be filled out Criteria 2: The DON or Nursing Supervisor will verify the posting of daily nursing staffing information in a location readily visible to residents, staff, and visitors that clearly reflects actual hours worked by the nursing staff. Locations include the Front Reception Desk, the 300 and 400 wings. Criteria 3: All licensed nurses have received inservice education on the requirement to post the required daily nursing staffing information in a location readily visible to residents, staff, and visitors that clearly reflects actual hours worked by the nursing staff, utilizing a template form that can be filled out as provided by the DON and Administrator on 12/22/25. Criteria 4: The DON will monitor the posting of daily nursing staffing information weekly to determine if it is being completed as required. Results will be reported to QAPI monthly times 12 months. 12/31/2025 DA	12/26/2025

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F0732 SS = F	Continued from page 35 facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the provider failed to post the required daily nursing staffing information in a location readily visible to residents, staff, and visitors that clearly reflected actual hours worked by the nursing staff for 18 of 18 days reviewed for November of 2025. Findings include: 1. Observation on 11/18/25 at 11:51 a.m. of the provider's Staffing Census Sheet revealed: *It was posted on the wall beside a door labeled "staff only" behind the 400 hall nurses' station. *It was hanging approximately six feet off the floor. *It included the date and resident census. *Under the Day Shift heading of that form numbers documented behind the RN (registered nurse), LPN (licensed practical nurse), CMA (certified medication aide), CNA (certified nursing assistant), and Restorative/Activity Aide areas. *Under the Night Shift heading of that form numbers were documented behind the RN, LPN, and CNA areas. *Those documented numbers were not identified as to what they represented. 2. Interview on 11/18/25 at 11:51 a.m. with LPN/restorative nurse N revealed the Staffing Census Sheet was only posted in the 400 hallway. 3. Observation on 11/19/25 at 10:35 a.m. of the Staffing Census Sheet revealed there were zeros documented behind the day shift and night shift RN. 4. Interview on 11/20/25 at 8:03 a.m. with resident 5 revealed: *Resident 5 was seated in her wheelchair below the Staffing Census Sheet hanging on the wall. *When she was asked if she was able to read the Staffing Census Sheet, she stated it was too high, but she thought she could if it was lowered.	F0732		

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F0732 SS = F	Continued from page 36 *The Staffing Census Sheet was lowered down in front of resident 5, and she read the entirety of the sheet. *She stated she was unsure what the numbers on the form meant. 5. Interview on 11/20/25 at 12:06 p.m. with LPN O revealed: *The night nurse was responsible for the completion of the Staffing Census Sheet. *It was completed each night according to the assignment sheets that were completed by management up to three days prior. *Nursing staff attempted to keep the Staffing Census Sheet up to date if there were any staffing changes. *Leadership staff hours were not included on the Staffing Census Sheet. *Leadership staff assisted with resident cares and daily tasks on the floors when needed. *The numbers behind RN, LPN, CMA, CNA, and Restorative/Activity Aide represented scheduled hours. *She verified the Staffing Census Sheet did not identify what the numbers represented. *She stated the Staffing Census Sheet was only displayed on the 400 hallway and would not be readily visible for residents or family members on the 300 hallway. *She verified that the Staffing Census Sheet was not readily visible to residents in wheelchairs due to the height it was posted. 6. Review of the Staffing Census Sheets from 11/1/25 through 11/19/25 revealed that on 11/1/25, 11/8/25, and 11/19/25 the Staffing Census Sheet indicated there were no RNs on duty during those day or night shifts. 7. Interview on 11/20/25 at 4:32 p.m. with administrator A and Minimum Data Set (MDS) consultant I revealed: *Administrator A verified the 11/19/25 Staffing Census Sheet for RN hours was not accurate because Administrator A was an RN and director of nursing (DON) B was an RN, and both of them were in the building	F0732		

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F0732 SS = F	Continued from page 37 available to assist residents during the day shift on 11/19/25. *She the posted Staffing Census Sheet was not readily accessible to all residents, staff, and visitors. *She agreed the numbers on the Staffing Census Form behind RN, LPN, CMA, CNA, and restorative/activity aide were not clearly identified as to what they represented. *She stated there were no days when an RN was not scheduled to be in the facility. A provider's policy for the daily nurse staff posting was requested on 11/19/25 at 8:30 a.m. and was not received by the conclusion of the survey.	F0732		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure temperatures were maintained	F0761	F 761 Label/Store Drugs and Biologicals Criteria 1: A new medication room log form has been implemented for monitoring of the daily medication room temperature. Criteria 2: The medication administration staff will complete the medication room temperature log at the beginning of the day shift and will immediately notify Maintenance staff for any temperature reading that is outside of the posted required range. Maintenance will check the heating/cooling units to ensure that they are working correctly, and all necessary equipment will be maintained for efficiency. 12/31/2025 DA Criteria 3: The medication administration staff and maintenance have received inservice education on the new medication room temperature log and the monitoring/reporting process as provided by the DON and Administrator on 12/22/25. Criteria 4: The QAPI audit for the monitoring of medication room storage temperatures will be utilized by the DON/ADON monthly, X 2 months, and then quarterly thereafter. The completed QAPI audits will be reviewed in the quarterly QAPI meetings to monitor compliance and any indicated action plans	12/26/2025

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F0761 SS = E	Continued from page 38 within a proper temperature range for safe medication storage in one of one medication room. Findings include: 1. Observation and interview on 11/20/25 at 12:32 p.m. with registered nurse (RN)/ staff development K in the medication room revealed: *She stated the facility had one medication room. *The medication room felt significantly warmer than the hallway outside the medication room. *There was documentation on the side of the refrigerator in the medication room which contained daily temperature readings from the refrigerator and freezer. *There was no documentation of temperatures for the medication room itself. *When asked if the temperature of the medication room were monitored, RN/staff development K pointed to the thermostat on the wall which was set at 72 degrees Fahrenheit (F). *RN/staff development K stated she did not know of any temperature monitoring or documentation for the medication room. 2. Interview on 11/20/25 at 3:04 p.m. with RN/infection control (IC) C and licensed practical nurse (LPN)/restorative nurse N revealed: *There was no temperature monitoring or documentation for the medication room temperature to ensure it was in a safe medication storage range. *RN/IC C stated the temperature of the medication room had not been monitored in the five years she had been employed at the facility. 3. Interview on 11/20/25 at 5:38 p.m. with director of nursing (DON) B revealed: *The temperature of the medication room often seemed warmer or cooler than the rest of the facility, but she was not aware if the temperature of the medication room had ever been checked to determine what the temperature was in the medication room. *The temperature of the medication room was not monitored to ensure it was in a safe medication storage	F0761		

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F0761 SS = E	Continued from page 39 range. *She was not aware the medication room was required to be maintained between 59- and 86-degrees F for safe storage of medications. Review of the provider's February 2023 Medication Labeling and Storage policy revealed: *"The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls." *"The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner."	F0761		
F0801 SS = D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the	F0801	F 801 Qualified Dietary Staff Criteria 1: The new RD is working as a consultant for the facility and is overseeing the Dietary Manager until she completes the certification training. Dietary Manager was enrolled on 11/07/2025 with an expected completion date by 01/30/2026. 12/31/2025 DA Criteria 2: The new RD will be performing training, food service oversight, and meal preparation/tray accuracy and delivery monitoring as a consultant for the facility until the Dietary Manager completes the certification training. Criteria 3: The Dietary Manager and dietary staff have received in-service education on dietary sanitation and meal preparation/tray accuracy. RD approved the in-service material, and it was completed on 12/22/2025 by Staff Development. Criteria 4: The QAPI audit tool for the monitoring of dietary sanitation and tray accuracy will be utilized monthly by the RD, Staff Development, and Infection Control Nurse. The QAPI audit findings will be reviewed in the facility's QAPI meetings quarterly.	12/31/2025

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F0801 SS = D	Continued from page 40 services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.	F0801		

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F0801 SS = D	Continued from page 41 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the provider failed to ensure one of one dietary manager (DM) (F) was certified according to the requirements. Findings include: Interview on 11/20/2025 at 11:14 a.m. with DM F revealed: *She was hired on 3/6/2013 as the dietary manager. *She was not a certified dietary manager. *Registered dietitian (RD) H had encouraged DM F to take the certified DM course. -DM F had registered for the DM course and had started it the week prior to 11/20/25. -DM F had registered for the DM course "a year ago," but a personal situation happened, and she was not able to complete it. Interview on 11/20/25 at 1:14 p.m. with administrator A regarding DM F's certification revealed: *She confirmed DM F was hired in 2013 and was not certified. *DM F was unable to complete the course in past years for various reasons. *DM F was enrolled in a DM certification course currently. Review of DM F's employee file revealed she was hired on 3/16/13, there was no documentation that she had taken a dietary manager course in the past.	F0801		
F0808 SS = F	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician.	F0808	F 808 Therapeutic Diet Prescribed by the Physician Criteria 1: Residents 1, 2, 4, 5, 6, 7, 14, 17, and 18 are served foods in the appropriate form according to their physician-ordered therapeutic diets, as determined by tray accuracy audits completed on 12/22/202 by Dietary Manager, Safe Serve Cook, and /or staff Development.	12/26/2025

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F0808 SS = F	Continued from page 42 §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, record review, and policy review, the provider failed to ensure nine of nine sampled residents (1, 2, 4, 5, 6, 7, 14, 17, and 18) were served foods in the appropriate form according to their physician-ordered therapeutic diets. Findings include: 1. Observation and interview on 11/18/25 at 12:01 p.m. with dietary aide T revealed: *He served whole chicken breasts, whole slices of ham, and cubed pieces of ham that were approximately one-inch pieces. *He did not have residents' diet cards to reference what the residents' ordered diets were. He explained that he had worked here for a year and had the residents' diets memorized and had a cheat sheet, so he knew which residents should be served the chicken breasts, as they were for residents on heart-healthy diets. *There was a list posted on a cupboard that listed all the residents' diet orders. *All the mechanical soft residents were served the cut-up ham. *He did not have any ground meat prepared to serve to residents. *He added carrot cake to all the meal plates before serving them to residents, including the residents with orders for consistent carbohydrate diets. *For residents with orders for no-added-salt (NAS) diets, he indicated that meant that salt was not added to their food. 2. Observation on 11/19/25 at 5:15 p.m. in the dining room revealed that no residents had ground meat on their meal plate, and any cut-up meat was in approximately one-inch-sized pieces. 3. Review of resident 4's 9/26/25 electronic medical record (EMR) revealed:	F0808	Criteria 2: Current residents are served food in the appropriate form according to their physician-ordered therapeutic diets as determined by tray accuracy audits completed by Staff Development, MDS Coordinator on 12/22/25. Criteria 3: The Dietary Manager and dietary staff have received inservice education on dietary sanitation and meal preparation/tray accuracy from the Staff Development and Infection Control Nurse, as completed on 12/22/25. The RD approved all training, and then SD completed all approved training. 12/31/2025 DA Criteria 4: The QAPI audit tool for the monitoring of dietary sanitation and tray accuracy will be utilized monthly by the RD. The QAPI audit findings will be reviewed in the facility's QAPI meetings quarterly.	

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F0808 SS = F	Continued from page 43 *He had physicians' orders on 11/7/25 for a mechanical soft diet. *He was dependent on one staff member to assist him with eating, required a mechanical soft diet, and had only a few of his teeth left. *His current care plan indicated he had a nutritional problem due to having a mechanical soft diet and needing staff to assist him with eating. *A 9/27/25 registered dietitian's progress note indicated: his diet order was for a regular diet, with mechanical soft textures, thin liquids, and the RD recommended to continue that same diet. 4. Review of resident 5's EMR revealed: *She had physicians' orders on 8/25/25 for a heart-healthy, mechanical soft diet. *Her current care plan indicated she did not wear her top dentures, she had her own bottom teeth, and she was to follow her diet as ordered and to consult with the dietician and change if chewing/swallowing problems were noted. 5. Review of resident 6's EMR revealed: *His current care plan indicated he required a consistent carb, heart-healthy diet; it did not indicate he required a mechanical soft diet per his physician's orders, had several teeth extracted, and he would eat other residents' food if left at the table and choked and/or coughed when eating and drinking at times. * He had physicians' orders on 4/15/25 for a mechanical soft diet and all his food cut up into one-quarter-inch pieces. 6. Review of resident 18's 11/17/25 care plan revealed she: *Her current care plan indicated she had dental health problems related to broken teeth, was to have her diet as ordered and consult with the dietician and change if chewing/swallowing problems were noted, had potential nutritional problems, so she required a mechanical soft diet. *She had physicians' orders on 10/6/25 for a regular diet with a mechanical soft texture.	F0808		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 57625**

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F0808 SS = F	Continued from page 44 7. Observation and interview on 11/19/25 at 5:30 p.m. with certified nursing assistant (CNA) CC revealed: *She had resident 4's plate, and it contained a whole piece of pork cutlet, mashed potatoes, a slice of bread, canned apricots cut in half, and a cup of bean soup. *She was to cut up his food and feed it to him. *He has difficulty chewing big pieces of meat. 8. Interview on 11/17/25 at 2:30 p.m. with dietary manager F revealed: *The current menus were from last year and were not signed off by a dietician, as they did not have one. *The new menus were being created and then would be sent to the dietician for approval. *She has to complete training for the new menu system. *The RD H was the new dietician for the facility. 9. Interview on 11/20/25 at 11:14 a.m. with dietary manager F revealed: *She had been the dietary manager at the facility since 3/6/13. *Resident 1 was to have ground meat. However, at a care conference, it had been changed to being cut up, per her preference. The order should reflect that, but it does not. *The dietician wanted her to try the ground meat again to see if she would accept it. *Resident 14 was to have ground meat, but did not like it. *Mechanical soft diets should be prepared in one-quarter-inch pieces and add gravy to it to make it moist. *She agreed, the one-inch pieces of meat were too large for a resident who required a mechanical soft diet. *She indicated resident 4 was on a regular diet, but said they cut it up for him. After looking at the diet order, she verified that resident 4 was to have a mechanical soft diet and the CNA would not be able to	F0808		

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F0808 SS = F	Continued from page 45 easily cut his meat into one-quarter-inch pieces and add gravy to it in the room. 10. Interview on 11/20/24 at 4:10 p.m. with administrator A revealed: *She verified that the current menus followed to serve residents were not signed as RD H, the new dietician, did not feel comfortable with their current menu system. *They purchased a new menu system three weeks ago, and the training on that needed to be completed and was scheduled for the next day. 11. Interview on 11/20/25 at 5:09 p.m. with registered dietician H revealed: *The facility's menus were not signed by her before the survey, as she determined they did not include nutritionally appropriate menu extensions. *Mechanical soft diets were comparable to the National Dysphagia Diet level 3 (NDD3) and would require meats cut up into pieces smaller than one inch, unless the doctor's orders specified something else. *The mechanical soft diet allowed for some interpretation of the diet, and she had past experience of a speech therapist or a doctor who indicated the size of meat pieces, but the facility did not have a speech therapist to do this. *The meat of the mechanical soft diet was to be moist, tender, and easily mashed with a fork. *If a resident did not want to follow their physician-ordered diet, they had the resident/family sign a risk/benefits form to complete. 12. Review of resident 2's electronic medical record (EMR) revealed His diet order was "Renal, Consistent Carb [carbohydrate] diet Regular texture, Regular consistency, 1400cc [cubic centimeters] Fluid restriction- 900cc Dietary, 500cc Nursing, 300cc with each meal by dietary=900cc 200cc with each water pass, 2 passes= 400cc sips with med [medicine] pass, 3passess= 100cc. If more than 3 med passes, use from water pass in room." 13. Review of resident 17's EMR revealed: *She was admitted on 3/18/25.	F0808		

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F0808 SS = F	Continued from page 46 *Her diet order was "Consistent Carbohydrate diet Regular texture, regular consistency, 2 gram sodium". 14. Interview on 11/18/25 at 9:00 a.m. with resident 14 revealed she: *Did not have any teeth. *Stated she could not chew hard food, but that was what she was given so she did not eat all her meals. 15. Observation on 11/19/25 at 5:24 p.m. of resident 14's meal plate revealed she was served a pork cutlet cut into pieces approximately one inch by one-half inch. 16. Review of resident 14's EMR revealed: *She was admitted on 11/9/23. *Her 11/5/25 BIMS assessment score was 15, which indicated she was cognitively intact. *Her diagnoses included diabetes, abnormality of plasma protein (an increase or decrease in protein levels often indicating an underlying condition such as liver disease, kidney problems, nutritional deficiencies, or certain cancers), and muscle wasting (muscle loss). *Her diet order was, "Consistent Carb [carbohydrates], NAS [no added salt] Mechanical soft, Ground Meat texture, Regular consistency, Arginaid [a nutritional supplement to support wound healing] BID [two times per day] with meals for skin, Offer Yogurt at Breakfast, and Large Protein Portions at all meals." *Her 11/20/25 care plan stated she had no teeth or dentures. 17. Observation on 11/19/25 at 5:48 p.m. of resident 1 during the supper meal revealed she was served a pork cutlet cut into one-inch cubes with gravy over it. She did not eat the cut-up meat. She had eaten the rest of her meal. Review of resident 1's EMR revealed her 3/22/25 therapeutic diet order was "Consistent Carbohydrate diet, Mechanical Soft, Ground Meat texture, Nectar consistency, with ground meats add extra gravy". 18. Review of the providers 10/2025 Therapeutic Diet Orders policy revealed:	F0808		

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F0808 SS = F	Continued from page 47 *" The facility provides all residents with foods in the appropriate form and/or appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences." *" Definitions: - 'Mechanically Altered Diet' is one in which the texture or consistency of food is altered to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. -'Therapeutic Diet' is a diet ordered by a physician, or delegated registered or licensed dietitian, as part of treatment for a disease or clinical condition. It also may be ordered to eliminate, decrease or increase specific nutrients in the diet. Examples include low salt, diabetic, or low cholesterol diets. A mechanically altered diet is not automatically considered a therapeutic diet." 1. Each resident's nutritional status is assessed by the interdisciplinary team in accordance with assessment policies. 2. Therapeutic diets, including mechanically altered diets where appropriate, will be based on the resident's individual needs as determined by the resident's assessment. Therapeutic diets may be considered in certain situations, such as, but not limited to: a. Inadequate nutrition b. Nutritional deficits c. Weight loss d. Medical conditions such as diabetes, renal disease, or heart disease. e. Swallowing difficulty 3. Therapeutic diets are provided only when ordered by the attending physician or registered or licensed dietitian who has been delegated to write diet orders, to the extent allowed by state law. Should the attending physician delegate the prescribing of therapeutic diets, he or she will supervise the dietitian and remain responsible for the resident's care.	F0808		

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F0808 SS = F	Continued from page 48 4. The reason for the therapeutic diet is to be documented in the medical record and/or indicated on the resident's comprehensive plan of care. All diet orders are to be communicated to the dietary department in accordance with facility procedures. 5. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed...."	F0808		
F0812 SS = L	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: A. Based on observation, interview, record review, manufacturer's instruction review, and policy review, the provider failed to ensure that staff followed standard food safety practices to sanitize dishware used to prepare and serve residents' food to prevent potential food-borne illness. That failure had the potential to affect all 28 residents who resided in the facility and placed them in immediate jeopardy for harm, illness, or death.	F0812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary Criteria 1: - The new dishwasher has been installed and is being utilized as of 11/26/25. A new dishwasher temperature log was created for use. -Prior to the installation the Dietary Manager or designee implemented the following: -The dietary manager or designee provided the three-compartment sink sanitation log form reach for dietary staff each Tuesday of the month. -Re-education of dietary staff was completed by the Dietary Manager and LPN on proper procedure of sanitation range, testing the sanitizer chemical, and ensuring the three-compartment sink is functioning properly after being educated by the Administrator. Education was approved by RD and was completed by Staff Development . -The facility obtained the correct test strips delivered on 11/24/25. -LPN completed the sanitation strip test at the three-compartment sink. The test result was in the 200 range with an strip expiration date of 6/15/27. -Edits were made to the current three-compartment sink sanitizer log to include checking test strip expiration dates, monthly audit check list for Dietary Manager to complete, RD has added those items to her facility report to review during facility visits. Audit was monitored by DM or designee daily X 30 days, weekly x 8 weeks, and monthly X 12 months. It will be checked three times a day (Breakfast, lunch and dinner) by dietary staff members. If the result is out of range, the staff are to notify the dietary manager immediately within one hour. Education approved by RD and was completed by Staff Development . Criteria 2: -A PIP was in place on 11/19/25. -The RD is reviewing the audit check list items during facility visits. Criteria 3: Mandatory inservice education was completed for all dietary staff on 11/19/25 at 2:00pm by the Dietary Manager and facility nursing consultant. Verbal disciplinary instruction was given to all dietary staff members. The facility census of 28 displayed no symptoms of having food-borne illness as of 11/19/25. The residents have been eating meals without any complaints of nausea, vomiting, abdominal discomfort, or any elevated temperatures. Criteria 4: The QAPI audit for the monitoring of dietary sanitation will be utilized monthly by the DM or RD. The completed QAPI audits will be reviewed in the facility QAPI meetings quarterly to monitor compliance and any indicated action plans	12/26/2025

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F0812 SS = L	Continued from page 49 Findings include: 1. Notice of immediate jeopardy of F812 was given verbally and in writing on 11/19/25 at 10:25 a.m. to administrator A regarding: *Observation on 11/19/25 at 9:00 a.m. revealed the commercial dishwasher in the kitchen was not working. *Interview on 11/19/25 at 9:20 a.m. with dietary manager F and maintenance staff AA revealed that the dishwasher stopped working 10/30/25 at about 10:23 a.m. and could not be repaired. A new dishwasher was ordered, received on 11/14/25, and was not installed as of 11/19/25. Dietary Manager F revealed all dishes were being washed in the three-compartment sink, with sanitation occurring in the third compartment of that sink since the dishwasher was not operational on 10/30/25. DM F was asked to test the sanitation of the third compartment sink. The test strips to test the sanitation level showed an expiration date of 11/1/2023. DM F used one of those expired test strip to test the solution. That solution currently being used in the sink revealed the test strip did not change color to indicate proper sanitizer levels. The dietary manager was unable to find any other test strips to test the sanitizer level of the solution in the sink. The Dietary Manager confirmed there were no other supplies or other processes for the staff to know if the sanitizer level met the required level for proper sanitization of the dishes. *The above findings had the potential to cause serious widespread food-borne illness by failing to ensure sanitizer solution levels of 150 to 400 PPM (parts per million) according to the sanitizer's manufacturer's recommendations to effectively sanitize the dishes in a three-compartment sink. *A plan for the removal of the immediacy was requested at that time. IMMEDIATE JEOPARDY REMOVAL PLAN On 11/19/25 at 4:30 p.m. the provider submitted the following immediate jeopardy removal plan for review: *"Dietary Manager or Designee provides the Three-Compartment Sink Sanitization Log form ready for dietary staff each Tuesday of the month. Re-education	F0812		

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F0812 SS = L	Continued from page 50 of dietary staff completed by DM and LPN on proper procedure of sanitation range, testing the sanitizer chemical, and ensuring the three-compartment sink is functioning properly after being educated by the Administrator. *The New Dishwasher is in the facility awaiting installation. Eco Lab will be at the facility for chemical programming by Wednesday, November 26, 2025, for the new dishwasher. *Contacted Sysco Food and received the correct test strips. Order placed from the supplier for more sanitizer test strips. It will be delivered to the facility on Monday, November 24, 2025, from Amazon. *[Name redacted] [MDS consultant I] completed the sanitization strip test at the 3-compartment sink. The Test Strip Bottle arrived at 1310; the test was completed at 1320. The Test Result was in the 200 range, and a picture is attached to the result. The Test Expiration Date is June 15th, 2027. *Edits made to the current Three Compartment Sink Sanitizer Log to include checking test strip expiration dates, Monthly Audit Check List for Dietary Manager to complete, RD is adding those items to her facility report to review during her facility visits. Audit will be monitored by DM or Designee daily x30 days, weekly x 8 weeks, and monthly x 12 months. It will be checked three times a day (Breakfast, Lunch, Dinner) by Dietary Staff Members. If the result is out of range, they are to notify the dietary manager immediately within one hour. *PIP [performance improvement project] in place 11/19/2025. *Mandatory Inservice Education will be done with all dietary staff on 11/19/2025 at 2:00 pm, by the Dietary Manager [F] and [name redacted] [MDS consultant I], and a Verbal Disciplinary will be given to all dietary staff members. *Medicine Wheel Village Census of 28 displays no symptoms of having a food-borne illness as of 11/19/2025. They have been eating meals without any complaints of nausea, vomiting, abdominal discomfort, or any elevated temperatures." The IJ removal plan was accepted on 11/19/25 at 4:31 p.m.	F0812		

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F0812 SS = L	Continued from page 51 1. Observation and interview on 11/17/2025 at 2:10 p.m. with dietary aide T in the kitchen revealed: *There was a sign on the dishwasher that stated I did not work. *It stopped working about a week and a half ago. *A new dishwasher came in last Friday, and he was not sure when it would be installed. *To wash dishes, they used a three-compartment sink. The first compartment contained soap and water to wash, the second contained water to rinse, and the third contained sanitizer to sanitize the dishes. *Sanitizer levels were to be checked and documented once per day. *According to the November 2025 sanitizer level documentation sheet, the sanitizer level checks were not completed on 11/3/25, 11/15/25, 11/16/25, or 11/17/25. *When asked who was responsible for completing the sanitizer level checks, he replied, "whoever does it." *The checks were usually done in the morning before breakfast. *He reported he checked the sanitizer level today (11/17/25), but review of the sanitizer log indicated it was not documented yet. He then documented it, as within an acceptable range on the log. *They used ECOLAB Oasis 146 Mulit-Quat Sanitizer. *They did not check the temperature of the water. 2. Interview on 11/17/25 at 2:30 p.m. with dietary manager F revealed that if the sanitization levels of the three-compartment sink were not documented, she could not ensure that they met the required sanitization levels for effective sanitization. 3. Observation and interview on 11/18/2025 at 11:25 a.m. with dietary manager F in the kitchen revealed: *She removed her gloves, did not wash her hands, picked up a washcloth that was used to clean dishes from the first compartment of the three-compartment sink, wet	F0812		

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F0812 SS = L	Continued from page 52 the washcloth in the first compartment, and used that washcloth to wipe a cart and the counter. *The first compartment contained water and Dawn dish soap with a splash of bleach. *She washed dishes in the three-compartment sink. *When she was done washing dishes, she dried her hands on the apron she wore. *Without washing her hands, she put on oven mitts and took a pan out of the steamer. *She walked over to the dirty dishwasher area, dumped the pan's liquid contents into the sink, used the dish sprayer and sprayed out the inside of the pan, dumped that liquid into the sink, and then set the pan on the counter. *Without washing her hands, she obtained a thermometer and checked the temperature of the contents of what was that same pan, which was observed to be chicken breasts. *Those chicken breasts were to be served for lunch to the residents who had a heart-healthy diet ordered. *She washed a knife in the first compartment, rinsed it in the second compartment, did not put it in the third compartment of sanitizer, and put it on the drying rack. *She verified that she did not put the knife in the sanitizer solution. She then grabbed the knife, dipped it into the sanitizer solution, and did not let it sit for one minute in the sanitizer solution as the sign indicated. 4. Observation on 11/18/25 at 11:54 a.m. of dietary aide T in the kitchen revealed: *Plates were sitting on the cart, that was cleaned with soap and bleach water. *He moved plates from the cart to the counter, dished lunch meals on those plates for the residents, placed the plates of food back on that same cart, and served it to the residents using that cart. 5. Observation and interview on 11/19/25 at 9:00 a.m. with dietary manager F revealed:	F0812		

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F0812 SS = L	Continued from page 53 *The expiration date of the QT-40 sanitizer test strips was Nov 1, 2023. *She verified they were expired and thought she had more test strips, but she was unable to find them. *She placed an order for more sanitization test strips, but they were not expected to be delivered until Tuesday of the next week. *The dishwasher was scheduled to be installed the next Friday. *Residents were served food with reusable plates and cups and disposable silverware. 6. Interview on 11/19/25 at 9:20 a.m. with dietary manager F and maintenance staff AA revealed that the dishwasher stopped working 10/30/25 at about 10:23 a.m. 7. Interview on 11/19/25 at 10:25 a.m. with administrator A revealed: *They had been trying to get a vendor to come install the dishwasher. *The dishwasher came in last week. *She verified that the sanitization test strips were outdated and could not ensure the sanitizer solution met the levels required to sanitize the dishes using the three-compartment sink method. *She reported she was working on obtaining more sanitization test strips. 8. Interview on 11/19/25 at 1:10 p.m. with administrator A revealed they obtained unexpired sanitizer test strips, and that the dietary staff were coming in at 2:00 p.m. for education on using the sanitizer test strips. 9. Review of the provider's sanitizer log for the three-compartment sink from August 2025 through November 17, 2025, revealed that: *Sanitizer solution levels were not documented eight times in August 2025, fourteen times in September 2025, six times in October 2025, and three times in November	F0812		

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F0812 SS = L	Continued from page 54 2025. 10. Interview on 11/20/25 at 11:14 a.m. with dietary manager F revealed: *Staff were to wash their hands with soap and water when they entered the kitchen, between tasks, if they touched their face or hair, after taking trash out, and after doing dishes. *Staff were expected to dry their hands with a paper towel and not on their apron. *Rinsing the chicken on the dirty side of the dishwasher could contaminate the food and could cause residents to become ill. *She expected staff not to touch the food or the rim of the glass when serving it to residents. *She used bleach water to sanitize the counters and carts, and did not test its sanitation level. *Not ensuring sanitizer or bleach levels could put residents at risk for food-borne illness. 11. Interview on 11/20/24 at 4:10 p.m. with administrator A revealed that not completing hand washing, not checking the sanitizer levels, or using outdated sanitizer test strips to ensure accurate testing, could put residents at risk for food-borne illness. 12. Interview and observation 11/19/25 at 5:44 p.m. with dietary staff V revealed: *The sanitizer solution in the three-compartment sink was checked with test strips that were not outdated and was at an appropriate sanitization level of 150-400 ppm. The immediate jeopardy was removed on 11/19/25 at 5:44 p.m. after the survey team verified on site on 11/19/25 at 5:44 p.m. that the provider had implemented their removal plan through observation, document review, and staff interviews. After the removal of the immediate jeopardy, the scope and severity of the non-compliance remained an F. Current census was 28 residents.	F0812		

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F0812 SS = L	Continued from page 55 13. Review of the ECOLAB Oasis 146 Multi-Quat Sanitizer laminated sign posted on the wall by the third compartment sink revealed: *" Directions for use: Expose all surfaces of equipment, ware, or utensils to the sanitizing solution for a period of not less than one minute. Air dry." *" The testing solution should be at room temperature-65 degrees F-75 degrees F…testing solution should be at 150-400 ppm." 14. A review of the provider's 10/2025 Manual Warewashing-3 Compartment Sink policy revealed: *"To prevent the spread of bacteria that may cause food borne illness, this facility washes, rinses, and sanitizes pots, pans, and other utensils using a 3 compartment sink in accordance with current standards for food safety." *"The facility utilizes a 3 compartment sink to wash, rinse and sanitize pots, pans and other utensils to prevent the spread of bacteria that may cause food borne illness." *"A 3-step process is used to manually wash, rinse and sanitize dishware correctly: -First step: Thorough washing using hot water and detergent after food particles have been scraped off. -Second step: Rinsing with hot water to remove all soap residues. -Third step: Sanitizing with … a chemical sanitizing solution used according to manufacturer's instructions." *" A temperature measuring device shall be provided by the facility and readily accessible for frequent measuring of the washing and sanitizing temperatures." *" Sanitizing solutions shall be tested by a test kit or other device that accurately measures the concentration in MG/L [milligrams per liter]. Testing will occur periodically but not limited to: -When sink is initially filled, -At least once per shift, -With extended use, and	F0812		

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F0812 SS = L	Continued from page 56 -As needed." *The temperature of the wash solution in the manual warewashing equipment shall be maintained at not less than 110 degrees F or the temperature specified on the cleaning agent manufacturer's label instructions." *Sanitizing procedures for the three-compartment sink are as follows: -Step one, fill first sink/wash sink with hot water and detergent (follow product instructions), Fill second sink/rinse sink with hot clear water, fill third sink/sanitizing with...QAC ammonia at 150-200 ppm [parts per million]. Confirm appropriate temperature or concentration prior to washing and record on sanitation control log." -...Immerse rinsed pots/utensils in sanitizer per manufacturer instructions...." B. Based on observation, interview, and policy review, the provider failed to follow standard food safety practices to ensure food was served in a sanitary manner by dietary staff (T and U) who did not wash their hands or change their gloves after potentially contaminating them while serving meals to residents. 1. Observation on 11/18/25 of the noon meal service revealed: *Dietary staff U pushed a cart of various drinks from the kitchen to the dining room with gloves on his hands. *With those same gloved hands, he handed out the drinks to the residents in the dining room, while also retrieving sugar, creamer, salt, and pepper from a drawer on the cart for the residents. *With those same gloved hands, he touched the drinking rims of one coffee cup and two juice glasses while he provided them to three different residents. *Dietary staff T had gloves on and pushed a cart out of the kitchen that had the residents' plated meals on it. *With those same gloved hands, he touched the plates beyond the rimmed edges of the plates and passed plates of food to the residents.	F0812		

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F0812 SS = L	Continued from page 57 *When he gave resident 31 and resident 9 their plated meals, he touched the food on their plates with his gloved hands. *Dietary staff T touched resident 9's food on her plate with the same gloved hand that he had touched resident 21's food with. He continued to pass plated meals to residents with those same gloved hands. 2. Review of the provider's August 2019 Handwashing/Hand Hygiene policy revealed: *"The facility considers hand hygiene the primary means to prevent the spread of infection." *"All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." *"Use and alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device (e.g. urinary catheters, IV [intravenous] access sites); f. Before donning sterile gloves; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident cares; i. After contact with a resident's skin; j. After contact with blood or body fluids; k. After handling used dressings, contaminated equipment, etc.; l. After contact with objects (e.g. medical equipment)	F0812		

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F0812 SS = L	Continued from page 58 in the immediate vicinity of the resident; m. After removing gloves; n. Before and after entering isolation precaution settings; o. Before and after eating or handling food; p. Before and after assisting a resident with meals; and q. After personal use of the toilet or conducting your personal hygiene." *"Hand hygiene is the final step after removing and disposing of personal protective equipment." *"The use of gloves does not replace hand washing/hand hygiene." *"Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves… 4. Hold the removed glove in the gloves hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. Review of the providers' 2001 Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices revealed: *" Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness." *" All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents." *" Employees must wash their hands: -…Before coming in contact with any food surfaces;… -After handling soiled equipment or utensils;	F0812		

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F0812 SS = L	Continued from page 59 -During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/or -After engaging in other activities that contaminate hands." *" Contact between food and bare (ungloved) hands is prohibited." *" Food service employees will be trained in the proper use of tongs, gloves…to prevent foodborne illness."	F0812		
F0868 SS = D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee.	F0868	F 868 QAA Committee Criteria 1: The Medical Director is participating in the facility QAPI meetings quarterly in person or by a Zoom type call with participation and recommendations recorded on the meeting minutes. Criteria 2: The QAPI Coordinator is documenting the participation and recommendations by the Medical Director in the facility quarterly QAPI meeting minutes. Criteria 3: The Medical Director was provided education on the regulatory requirements for participation in the facility quarterly QAPI meetings by the Director of Nursing on 12/22/25. Criteria 4: The QAPI meeting minutes will be reviewed by the Administrator upon completion each quarter to determine that they reflect the participation and recommendations of the Medical Director.	12/26/2025

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F0868 SS = D	Continued from page 60 The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: Based on interview and policy review, the provider failed to ensure Medical Director (BB) attended and meaningfully participated in the provider's Quality Assurance (QA) meetings at least quarterly. Findings include: 1. Interview on 11/20/25 at 3:33 p.m. with administrator A and Minimum Data Set (MDS) consultant I regarding the provider's QA meetings revealed: *QA meetings were held in person and through Zoom (a communications platform that provides real-time video meetings and other collaboration tools). *QA meetings were conducted every "four to five weeks". *The QA committee members included the maintenance supervisor, director of nursing B, administrator A, MDS consultant I, the MDS coordinator , staff development K, infection control preventionist C, the restorative nurse, and medical director BB. Medical director BB was provided information after the meetings and did not attend those meetings in person or through Zoom quarterly. *Administrator A was aware that medical director BB was required to attend the facility's QA meetings quarterly in person or through another real-time method, such as Zoom. Review of the provider's 2024 QA policies revealed: *"All identified problems will be addressed and prioritized, whether by frequency of data collection/monitoring or by the establishment of sub-committees chartered to complete performance improvement projects. Considerations include, but are not limited to:" -"High-risk, high-volume, or problem prone areas." -"Incidence, prevalence, and severity of problems in	F0868		

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F0868 SS = D	Continued from page 61 those areas." -"Measures affecting resident health, safety, autonomy, choice, and quality of care." *The policy did not indicate who comprised the QA committee or how often they were required to attend.	F0868		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a	F0880	F880 Infection Prevention & Control Criteria 1: The CNAs and license nurses that were identified in the 2567 as not following infection control standards of practice were included in the nursing inservice training in Criteria 3 and have had care observations performed to determine ongoing competency as completed by Staff Development, Infection Control Nurse on 12/17/25. Criteria 2: All residents had the potential to be affected by this cited deficiency, Criteria 3: Licensed and non-licensed nursing staff have received inservice education by Director of Nursing and/or Administrator as completed on 12/22/25 on adhering to infection control standards of practice, including but not limited to: correct hand hygiene and changing of gloves; correct use of PPE, adherence to transmission-based precautions. The education included Enhanced Barrier Precautions. 12/31/2025 DA Criteria 4: The QAPI audit tool for the monitoring of the Infection Control Program under the direction of the IP will be utilized monthly for 2 months and then quarterly thereafter by the DON and IP. Audits will be completed weekly for four weeks, then monthly for 10 months, and will be reported at QAPI monthly. 12/31/2025 DA	12/26/2025

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F0880 SS = E	Continued from page 62 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, interview, and policy review, the provider failed to ensure infection control practices were followed by: *Two of two certified nursing assistants (CNAs) (X and Y) who did not wear a gown while providing direct resident cares to one of one sampled resident (4) on enhanced barrier precautions (EBP) for a pressure ulcer. *One of one nursing assistant (NA) (Z) who did not change gloves and perform hand hygiene (handwashing) when she changed a resident 5's incontinence brief and assisted her into her wheelchair. *One of one licensed practical nurse (LPN) applicant (P) who did not perform hand hygiene during an insulin	F0880		

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F0880 SS = E	Continued from page 63 administration to resident 23. *One of one registered nurse (RN)/Minimum Data Set (MDS)/skin and wound nurse (L) who did not perform hand hygiene when she changed resident 14's dressing. Findings include: 1. Review of Resident 4's electronic medical record (EMR) revealed: *He was admitted on 2/3/25. *He had diagnoses of a pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) of the sacral region (low back), stage 3 (open wound with full-thickness skin loss. Fatty tissue may be visible). *He had 9/26/25 physician's orders for EBP related his use of a urinary catheter (flexible tubing inserted into the bladder to drain urine) and his sacral pressure ulcer. Resident 4's 9/26/25 care plan indicated: *He required EBP related to his urinary catheter and sacral pressure ulcer. -the staff were to "Follow facility protocol for enhanced barrier precautions as needed." -"Gowns and gloves [were] to be worn for high contact resident care activities." *He needed 2 staff to assist him with repositioning. *He had a pressure ulcer on his sacrum. -Staff were to "Administer treatments as ordered...." Observation on 11/17/2025 at 2:59 p.m. of CNAs X and Y with resident 4 in his room revealed: *He had a sign on his door indicating he was on enhanced barrier precautions. *He had a container hanging on a door in his room of gowns and gloves. *CNAs X and Y repositioned him, while wearing gloves but did not have gowns on.	F0880		

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F0880 SS = E	Continued from page 64 *He had a urinary catheter and a wound dressing on his sacrum. *CNA Y emptied his urinary catheter and did not have a gown on. 2. Review of Resident 5's electronic medical record (EMR) revealed: *She was admitted on 6/18/25. *Had diagnoses of non-pressure chronic ulcer of unspecified part of right lower leg with unspecified severity (a break in the skin that fails to heal due to poor circulation, not caused by prolonged pressure), cellulitis (bacterial skin infection) of right lower limb, and personal history of methicillin-resistant staphylococcus aureus infection(a type of staph bacteria that has become resistant to antibiotics) (MRSA). *She had a 10/23/25 physician's orders for EBP related to her skin wounds. Resident 5's 9/26/25 care plan indicated: *She required EBP related to her skin wounds. -The staff were to "Follow facility protocol for enhanced barrier precautions as needed." -"Gown and gloves [were] to be worn for high contact resident care activities. -The staff "Is to use Hoyer (a mechanical lift and sling used to lift a person's full body) with 2 assist [assistance by two staff members], when she refuses to use assist of 2 [staff members] with [the use of a] gait belt [a waist strap gripped as support for safe mobility and transfers]." *She had a chronic, open non-pressure ulcer to her right lower extremity (leg). -Her "Dressings [were] to be changed per MD [medical doctor] orders." Observation on 11/18/25 at 8:18 a.m. of CNA X and nursing assistant (NA) Z with resident 5 in her room revealed:	F0880		

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F0880 SS = E	Continued from page 65 *She had a sign on the outside of her door that indicated she required EBP. *She had a container over her bathroom door that contained gowns and gloves. *There was a Center for Disease Control and Prevention (CDC) sign posted on that container about multidrug-resistant organisms (a type of bacteria that resists many common antibiotics, making infections it causes very hard to treat)(MDROs). *There was a magnet on the outside of her door frame that stated "wash hands before and after patient care".. *While CNA X and NA Z were in resident 5's room and were wearing gowns, gloves and masks (PPE). -NA Z removed her incontinence brief, completed the resident's personal hygiene care, and then put a new incontinence brief on the resident. -With her same gloved hands,NA Z pulled the residents pants up, put a lift sling under her, hooked the sling to the total body lift, transferred her into her wheelchair, and pushed her in the wheelchair. -CNA X and NA Z removed their PPE and performed hand hygiene. -NA Z then pushed the total body lift into the hallway and did not clean the lift. 3. Interview on 11/18/25 at 8:20 a.m. with travel contracted registered nurse M revealed resident 5 had a history of MRSA, and gowns and gloves needed to be worn by staff when providing direct care for the resident. 4. Interview on 11/20/2025 at 10:18 a.m. with CNA X revealed: *She had been a CNA at the facility for two months and previously worked in the dietary department. *When caring for residents who were on EBP, she would wear gloves, gowns, and masks. *Residents needed EBP if they had open wounds or a urinary catheter. *Staff were to wear gowns, gloves, and masks when dressing, repositioning, handling the urinary catheter	F0880		

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F0880 SS = E	Continued from page 66 and emptying the catheter bag, and transferring residents on EBP. *She verified she did not have a gown on when she repositioned resident 4 and should have. *She was to perform hand hygiene before putting on gloves and after removing gloves. *She was to remove dirty gloves and perform hand hygiene before completing clean tasks, such as pulling a resident's pants up and using the lift. *She was not aware she was to clean the lift after it was used or before using it for another resident, and verified the lift was not clean the lift after using it to assist resident 5. 5. Observation on 11/19/25 at 9:20 a.m. of licensed practical nurse (LPN) applicant P revealed: *LPN applicant P did not perform hand hygiene before she gathered the supplies for resident 23's insulin administration. *She put her gloves without having performed hand hygiene. *With her gloved hands LPN applicant P touched the keyboard on the computer on the medication cart. *LPN applicant P entered resident 23's room, administered the resident's insulin, removed her gloves, and then exited resident 23's room. *LPN applicant P returned to the medication cart, applied alcohol-based hand sanitizer (ABHS) to the palm of her left hand. -She did not rub her hands together to apply the ABHS to her right hand or rub her hands together until the ABHS dried. 6. Observation and interview on 11/20/25 at 9:31 a.m. with registered nurse (RN)/ minimum data set (MDS)/skin and wound nurse L while changing resident 14's foot dressing revealed RN/MDS/skin and wound nurse L: *Entered resident 14's room, applied a gown, mask, and gloves. She did not perform hand hygiene before she put on her gloves. *Prepared the area for the dressing change, removed the	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	**24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 57625**

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F0880 SS = E	Continued from page 67 dirty dressing from resident 14's foot, removed her gloves and put on a new pair of gloves, cleaned the wound and placed a new clean dressing on the resident's foot wound. -Did not perform hand hygiene after she removed the dirty gloves used to remove the dirty dressing or before she applied put on clean gloves. *Verified she did not perform hand hygiene after she removed her dirty gloves or before she put on clean gloves during the above observed dressing change. *Stated she had performed hand hygiene before entering the room but agreed she touched items within the room before she put on her gown, mask, and gloves. 7. Interview on 11/20/25 at 3:04 p.m. with RN/infection control nurse C and LPN/restorative nurse N revealed: *Hand hygiene was expected to be completed before entering a room, after exiting a room, before gloves were applied and after they were taken off, before preparing each resident's medications, and after the medication administration, after a dirty procedure was completed and before a clean procedure such as during a dressing change or providing perineal personal hygiene care (washing of the genital and anal areas). *Mechanical lifts were to be cleaned with a disinfectant wipe after each resident use and as needed if they were visibly soiled. *Staff were to wear a gown and gloves while they provided direct care with a resident on EBP, to include repositioning the resident, and emptying a resident's urinary catheter. Review of the provider's April 2019 Administering Medications policy revealed, "Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable." 8. Review of the CDC EBP sign revealed: *"Wear gloves and a gown for the following High-Contact Resident Care Activities. -"Dressing…Transferring…Providing Hygiene…Changing briefs…Device care or use…Wound Care…."	F0880		

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F0880 SS = E	Continued from page 68 9. Review of the providers' 8/12/24 Enhanced Barrier Precautions policy revealed: *" Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities." *" All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions." *" All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions." *" An order for enhanced barrier precautions will be obtained for residents with any of the following: -"wounds...indwelling medical devices...." *" PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned [applied] prior to entering the resident's room." *" The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education." *" High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: ...urinary catheters.... h. Wound care: any skin opening requiring a dressing" 10. Review of the provider's August 2019 Handwashing/Hand Hygiene policy revealed: *"The facility considers hand hygiene the primary means	F0880		

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F0880 SS = E	Continued from page 69 to prevent the spread of infection." *"All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." *"Use and alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device (e.g. urinary catheters, IV [intravenous] access sites); f. Before donning sterile gloves; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident cares; i. After contact with a resident's skin; j. After contact with blood or body fluids; k. After handling used dressings, contaminated equipment, etc.; l. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; m. After removing gloves; n. Before and after entering isolation precaution settings; o. Before and after eating or handling food; p. Before and after assisting a resident with meals; and q. After personal use of the toilet or conducting your personal hygiene."	F0880		

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F0880 SS = E	Continued from page 70 *"Hand hygiene is the final step after removing and disposing of personal protective equipment." *"The use of gloves does not replace hand washing/hand hygiene." *"Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves… 4. Hold the removed glove in the gloves hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene."	F0880		
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on policy review, interview, and record review, the provider failed to develop and implement an effective antibiotic stewardship program to monitor for appropriate antibiotic use according to the provider's policy. Findings include: 1. Review of the providers 2024 Antibiotic Stewardship Program policy revealed: *"It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use." *"The program includes antibiotic use protocols and a	F0881	F 881 Antibiotic Stewardship Program Criteria 1: The IP has implemented the established facility components of the Antibiotic Stewardship Program reflecting one month of data collection. Criteria 2: The facility nurse consultant has reviewed the documentation for the implementation of the facility Antibiotic Stewardship program and assisted the IP with follow-up recommendations. Criteria 3: The IP has received inservice education by Proactive Consultant as completed on 12/17/25 on the implementation of the facility Antibiotic Stewardship program and the required components and documentation. Criteria 4: The QAPI audit for the monitoring of the facility Antibiotic Stewardship program will be utilized monthly X 2 months then quarterly under the direction of the IP and DON. QAPI audit results will be reviewed in the facility QAPI meetings quarterly to determine ongoing compliance	12/26/2025

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F0881 SS = D	Continued from page 71 system to monitor antibiotic use. -a. Antibiotic use protocols: --i. Nursing staff shall assess residents who are suspected to have an infection and complete a Medical Care Referral Form prior to notifying the physician. --ii. Laboratory testing shall be in accordance with current standards of practice. --iii. The facility uses the (CDC's [Center for Disease Control] NHSN [National Healthcare Safety Network] Surveillance Definitions) to define infections. --iv. The Loeb Minimum Criteria are used to determine whether or not to treat an infection with antibiotics." *"Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made (e.g. antibiotic time-out)." *"Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness." *"Random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness (process measure). *"At least one outcome measure associated with antibiotic use will be tracked monthly, as prioritized from the facility's infection control risk assessment and other infection surveillance data. Examples include: tracking C. difficile infections, antibiotic resistance, or adverse drug events related to antibiotic use." *"A review of the facility's antibiogram will be performed every 18-24 months to guide development or revision of antibiotic use protocols or prescribing practices." *"Nursing will monitor the initiation of antibiotics on residents and conduct an "antibiotic timeout" within 48-72 hours of antibiotic therapy to monitor response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings." *"At least annually or per facility policy, feedback shall be provided on the facility's antibiotic use data	F0881		

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F0881 SS = D	Continued from page 72 in the form of a written report shared with administration, medical and nursing staff, and the QAA [quality assessment and assurance] Committee." *"At least annually or per facility protocol, each attending physician shall be provided feedback on his/her antibiotic use data in the form of a written report". *"Documentation related to the program maintained by the Infection Preventionist, including but not limited to: -a. Action plans and/or work plans associated with the program. -b. Assessment forms. -c. Antibiotic use protocols/algorithms. -d. Data collection forms for antibiotic use, process, and outcome measures. -e. Antibiotic stewardship meeting minutes. -f. Feedback reports. -g. Records related to education of staff, residents, and families. -h. Annual reports." 2. Review of the provider's September 2017 Surveillance for Infections policy revealed: *"Nursing Staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infection, and will document and report suspected infections to the Charge Nurse as soon as possible." *"Analyze the data to identify trends. a. Compare the rates to previous months in the current year and to the same month in previous year, to identify seasonal trends. b. Consider how increases or decreases might relate to recent process changes, events, or activities in the facility (i.e., change in handwashing preparations, increased turnover in personnel or residents, etc.) c. If the infection rates rise each month over a period of six (6) months, additional advice is warranted."	F0881		

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F0881 SS = D	Continued from page 73 *"Surveillance data will be provided to the Infection Control Committee regularly." 3. Review of the provider's October 2025 Facility Assessment revealed: *"Describe how you evaluate if your infection prevention & [and] control program is effective in preventing, identifying, reporting, investigating & controlling infections & communicable diseases according to accepted national standards." -"Antibiotic Stewardship and monitoring -[Contracted] Telehealth -Utilize McGirrs [McGeers] and education on McGirr's training -I Car [Infection Control Assessment and Response] completion with SD [South Dakota] Dept. [Department] of Health -APIC [Association for Professionals in Infection Control and Epidemiology] and AHCA [American Health Care Association] memberships". 4. Interview and review of the provider's antibiotic stewardship binder on 11/20/25 at 3:04 p.m. with registered nurse (RN)/infection control (IC) C and licensed practical nurse (LPN)/restorative nurse N revealed: *RN/IC C was new to the position of infection control and antibiotic stewardship. *LPN/restorative nurse N had oversaw the antibiotic stewardship prior to RN/IC C starting that position. *The antibiotic stewardship binder contained a monthly breakdown of physician's orders for the antibiotics ordered that month for each resident and an annual listing of the antibiotics ordered for each resident. *Each month RN/IC C was responsible to print off the list of antibiotics for that month and present them to the QAPI (Quality Assurance and Performance Improvement) committee. *She was also responsible to be sure the lab results from any of the identified infections were in the resident's electronic medical record (EMR).	F0881		

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F0881 SS = D	Continued from page 74 *At the end of the year a report is run that lists all the antibiotics ordered and administered that year by resident. *McGeer criteria (a set of standardized definitions used in long-term care facilities, to identify and track infections for surveillance and research purposes) was used by the provider to identify potential infections. *There was no written documentation to support that McGeer criteria was being used when the staff suspected a resident had an infection prior to notifying the director of nursing or the practitioner. *RN/IC C and LPN/restorative nurse N stated they used common knowledge if a resident was suspected to have a urinary tract infection (UTI) and did not follow specific criteria to identify when the resident's symptoms met the criteria for a urinalysis (lab test for urine infection). *If the nursing staff suspected that a resident had an infection, they would report the information about that to the director of nursing (DON) B and she would relay that information to medical director BB. *If DON B was not available the nursing staff could utilize telehealth (electronic remote health service). *Nursing staff did not follow up in 48-72 hours after the initiation of an antibiotic to review the culture reports that indicated which antibiotic would be effective to treat that infection. Medical director BB would inform the nursing staff if the antibiotic was appropriate. 5.Interview on 11/20/25 at 5:38 p.m. with director of nursing (DON) C regarding the facility's antibiotic stewardship program and policy revealed: *When the nursing staff suspected a resident had an infection, they were to complete an assessment and then call DON B. DON B would then call medical director BB with the assessment information and medical director BB would give orders, such as, if the resident was to be monitored, have labs completed, or go to the emergency room. DON B would then notify the nursing staff and enter those orders, if applicable, into the resident's EMR. *Medical director BB recently begun ordering cultures to be completed with all urine samples collected.	F0881		

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F0881 SS = D	Continued from page 75 *DON B stated there was no written form for nursing staff to refer to or document on to determine if the criteria was met for a lab or to request an antibiotic. *Nursing did not review antibiotics for effectiveness 48-72 hours after an antibiotic was initiated (antibiotic timeouts). Medical director BB would receive the culture reports and notify the nursing staff if the antibiotic was appropriate. *There was no documentation of infections trends within the facility. *The provider did not use an antibiogram (a report summarizing antibiotic susceptibility test results for a specific population of bacteria, showing which antibiotics are effective against them) as their policy indicted. *There was no tracing of clusters or documentation that that information had been reviewed or evaluated with antibiotic use monthly, quarterly, or annually. *There was not a written action plan or work plan associated with the antibiotic stewardship program as the provider's policy indicated. *There were no written assessment forms as the provider's policy indicated. *There was no antibiotic use protocols as the provider's policy indicated. *There were no data collection forms for antibiotic use, process, and outcome measures as the provider's policy indicated. *There were no feedback reports or annual reports other than the listing of the antibiotics prescribed monthly and annually. *There were no records that education had been provided to physicians, residents, and families related to antibiotic stewardship.	F0881		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 11/18/2025. Medicine Wheel Village was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at E009 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E0000		
E0009 SS = D	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis	E0009	E0009 Local, State, Tribal Collaboration Process Criteria 1: The Maintenance Director has contacted local emergency management to arrange for participation in a community-oriented disaster drill for the facility. Local Emergency Management will be in the facility on 12/30/2025. It was lined up to be completed by 12/31/2025. Criteria 2: The Administrator and Director of Maintenance have developed an annual calendar for desktop and disaster drills for the facility, including a community-oriented disaster drill. Criteria 3: The Maintenance Director received in service education on the need for a community-oriented disaster drill for the facility as provided by the Administrator and Surveyor during the Survey Criteria 4: The QAPI audit tool for the monitoring of the Emergency Preparedness program, including the community-oriented disaster drill will be utilized quarterly by the Administrator and/or Maintenance Director.	12/31/2025 DA

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deb Arbogast	Nursing Home Administrator	12/23/2025

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E0009 SS = D	Continued from page 1 facility's needs in the event of an emergency. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to include a process for cooperation and collaboration with local, regional, or state emergency preparedness officials to maintain an integrated response during a disaster or emergency situation and document participation in such events. Findings include: 1. Document review on 11/18/25 at 10:00 a.m. revealed the provider did not conduct a community-oriented disaster drill for the facility from November 2024 to November 2025. Interview with the administrator at on 11/18/25 at 11:00 a.m. confirmed that finding. She stated the provider had performed in-house training for tornado drills and fire drills. The deficiency affected one of numerous requirements for emergency preparedness.	E0009		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

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K0000	INITIAL COMMENTS A recertification survey was conducted on 11/18/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Medicine Wheel Village was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K222 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0222 SS = D Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is	K0222	All exit door mag lock functionality will be tested by maintenance, who will test the doors' operation and locks weekly for four weeks, then monthly thereafter and report to QA.	12/26/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deb Arbogast	Nursing Home Administrator	12/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 57625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0222 SS = D Bldg. 01	Continued from page 1 constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENT Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENT Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain one of six (400 wing EXIT) delayed egress magnetic locks for egress as required. Findings include: 1. Observation and testing on 11/18/25 at 9:45 a.m. revealed the EXIT door for the 400 wing was equipped with a magnetic lock that had delayed egress signage. Testing of the door by pushing on the panic bar revealed the magnetic lock began blinking as if to begin the release function. Upon release of the panic bar, the sequence stopped and the door did not release. Exiting was not possible. Immediate re-testing of the door did show the delayed egress magnetic lock did function upon a second attempt to open the door. The door's magnetic lock also had a sensitivity knob. The	K0222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A138	A. BUILDING 01 - MAIN B. WING	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicine Wheel Village	24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 57625

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K0222 SS = D Bldg. 01	Continued from page 2 plant operations director stated the sensitivity could be adjusted to provide stronger magnet operation. The magnet when adjusted in such a manner would prevent a delayed egress operation. Failure to provide egress doors as required increases the risk of death or injury due to fire or other emergencies. Interview with the plant operations director at the time of the observation confirmed that finding. The deficiency could affect 100 percent of the smoke compartments occupants.	K0222		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68814	A. BUILDING: _____ B. WING _____	11/20/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/17/25 through 11/20/25. Medicine Wheel Village was found not in compliance with the following requirements: S157, S206, and S294.	S 000		
S 157	44:73:02:13 Ventilation A facility shall provide electrically powered exhaust ventilation in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to ensure two of five storage rooms (main laundry soiled holding room and the janitor's closet by the kitchen) were equipped with working exhaust ventilation. Findings include: 1. Observation on 11/18/25 at 10:45 a.m. revealed the main laundry soiled holding room was equipped with exhaust ductwork. Testing of the exhaust switch at the time of the observation revealed the exhaust fan was not working. 2. Observation on 11/18/25 at 10:55 a.m. revealed the janitor's closet by the kitchen was equipped with exhaust ductwork. Testing of the exhaust switch at the time of the observation revealed the exhaust fan was not working.	S 157	Maintenance will inspect exhaust fans for proper operation and cleanliness. Weekly for four weeks, then monthly thereafter. Monitoring will be completed by Maintenance.	12/26/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deb Arbogast — TITLE: Nursing Home Administrator — (X6) DATE: 12/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68814	A. BUILDING: _____ B. WING _____	11/20/2025

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S 157	Continued From page 1 3. Interview with the plant operations director at the times of the testing confirmed those findings.	S 157		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review and interview,	S 206	Relais Training for Employee F, U and W completed 12/22/2025. The 12 required educational modules were updated in Relias Education Platform. Staff Development and HR will audit all new hires before day 30 and annually. Staff Development will report monthly to QAPI. All new hires audit for completed required training completed within 30 days upon hire and annually there after and will be reported monthly to QAPI x 12 months. 12/31/2025 DA All training is set up to start for all employees in January and to end on May 1st every year, therefore after	12/26/2025 12/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68814	A. BUILDING: _____ B. WING _____	11/20/2025

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S 206	Continued From page 2 the provider failed to ensure: *Two of three sampled employees (U and W) had completed the required orientation training topics within 30 days of hire. *Two of two sampled employees (F and Q) had completed the required annual training topics: Findings include: 1. Review of dietary employee U's employee file revealed he: *Was hired on 7/17/25. *Had not completed the required orientation training topic of advance directives within 30 days of hire. 2. Review of activity and certified nursing assistant (CNA) W's employee file revealed she: *Was hired on 4/10/25. *Had not completed the following required orientation training topics within 30 days of hire: -Accident prevention and safety procedures. -Proper restraint use. -Advanced directives. 3. Review of dietary manager F's employee file revealed she: *Was hired on 3/6/13. *Had not completed the following required ongoing training topics within the last twelve months (annually): -Proper restraint use. -Mandatory reporting and incidents and diseases. -Advanced directives. 4. Review of activity and CNA Q's employee file revealed she: *Was hired on 1/14/19. *Had not completed the following required ongoing training topics within the last twelve	S 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 206	Continued From page 3 months (annually): -Accident prevention safety procedures. -Mandatory reporting and incidents and diseases. 5. Interview on 11/20/25 at 1:16 p.m. with administrator A regarding employee training reveal licensed practical nurse (LPN)/restorative nurse N was responsible for ensuring employee orientation and ongoing training were completed within the required time frame. Interview on 11/20/25 at 3:20 p.m. with LPN/restorative nurse N regarding employee training revealed: *She was responsible for ensuring orientation and ongoing training were completed for the above four employees and all employees. *She was not sure how she had "missed" that the above employees had not completed their orientation and annual training.	S 206		
S 294	44:73:07:09 Written Menus Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as ordered by each resident's physician, physician assistant, nurse practitioner, or authorized dietitian. Each menu must be written at least one week in advance. A dietitian shall annually approve, sign, and date each planned menu for the facility. The dietitian shall review any menu changes from month to month. Each menu served must meet the nutritional needs of the resident in accordance with the orders of a physician, physician assistant, nurse practitioner, or dietitian and the Dietary Guidelines for Americans, 2020-2025. The facility shall file and retain a record of each menu as	S 294	Menu's were updated per 4 week rotation and with menu extensions per RD recommendation. Audits will be completed by the Dietary Manager, Staff Development, Infection Control Nurse, and/or Administrator weekly x4, then monthly thereafter. Audits will assure the menu and menu extension is followed and reported to QAPI monthly x 12 months. 12/31/2025 DA	12/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 294	Continued From page 4 served for thirty days. This Administrative Rule of South Dakota is not met as evidenced by: Based on interviews and record review, the provider failed to ensure the menus were signed and approved by a dietitian annually as required. Findings include: 1. Interview on 11/17/25 at 2:30 p.m. and on 11/20/25 at 11:14 a.m. with dietary manager F revealed: *They have not had a consultant dietitian for a year until around October 2025. *The current menus they were using were from last year and were not signed off by a dietitian, as they did not have a consultant dietitian at that time. -She provided a letter she received from the previous dietitian regarding the menu approval for the menus, which were last approved on 9/19/2023. *The new menus were being created and then would be sent to the current dietitian H for approval after that. 2. Interview on 11/20/25 at 4:10 p.m. with administrator A revealed: *She verified the current menus were not signed because their new consultant dietitian H did not feel comfortable with their current menu system, and she knew they were supposed to be signed annually. *They purchased a new menu system three weeks ago, and the training needed to be completed and was scheduled for tomorrow. 3. Interview on 11/20/25 at 5:09 p.m. with	S 294		