STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435033	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westhills Village Health Care Facility	**255 TEXAS ST , RAPID CITY, South Dakota, 57701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 3/10/26 through 3/12/26. Westhills Village Health Care Facility was found not in compliance with the following requirements: F578, F684, and F880.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an	F0578	Westhills Village Health Care operates in compliance with all relevant regulations and professional standards in a manner that ensures safe and appropriate care with an emphasis on residents' rights for all residents we serve. In reference to F578, advance directives of five sampled residents reviewed will be assessed to ensure that advance directives were discussed with resident and/or POA and care plan represents current code status on or before April 26, 2026. Documentation will be reviewed by Social Service Director and/or designee to ensure compliance. The Social Service Director or designee will conduct an audit weekly for one month, then monthly for two months with all new admissions to ensure advance directives have been discussed and documented appropriately. Results will be reviewed by the QAPI committee for recommendations.	04/26/2026

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelsey Bertsch	Executive Director	04/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435033	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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F0578 SS = D	Continued from page 1 advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure that the current advance directives (a document that expresses a person's health care wishes if they become unable to speak for themselves) for five of five sampled residents (7, 13, 26, 27, and 60) were in the residents' medical records according to the provider's policy. Findings include: 1. Review of resident 7's medical record revealed she admitted to the facility on 9/1/23. There was no documentation indicating that any advance directive paperwork, which expressed her wishes regarding her code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop), was completed upon admission. 2. Review of resident 13's medical record revealed she admitted to the facility on 5/12/21. There was no advance directive or document that indicated her wishes regarding her code status in her medical record. 3. Review of resident 26's medical record revealed she admitted to the facility on 10/29/25. A progress note dated 10/30/25 by executive director (ED) A indicated she had completed admission paperwork with resident 26, including the advance directive information. There was no advance directive in her medical record. 4. Review of resident 27's medical record revealed she admitted to the facility on 10/2/25. There was no documentation that the resident completed any advance directive paperwork on admission. There was a progress note on 10/2/25 completed by ED A that stated she had completed admission paperwork with resident 27 that which included advance directive information.	F0578		

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F0578 SS = D	Continued from page 2 5. Review of resident 60's medical record revealed he admitted to the facility on 11/11/25. There was a copy of his admission paperwork, including his baseline care plan in his medical record. That paperwork did not include his advance directive. 6. Interview on 3/11/26 at 3:36 p.m. with interim director of nursing (IDON) B revealed that their process for documenting a residents' advance directive wishes was to identify those wishes on the resident's baseline care plan and to keep that care plan in each resident's medical record for the staff to refer to. She acknowledged that resident 60's baseline care plan did not address his advance directives. She acknowledged that the baseline care plans for several residents were not available because she could not find copies of them or they were removed from the resident's medical record and stored at an offsite location and would have to retrieve them, as part of their record thinning process. She acknowledged that without that documentation in their medical records, the code status or those residents could not be confirmed by the staff to honor those wishes. 7. Interview on 3/12/26 at 9:56 a.m. with ED A and IDON B revealed that social service coordinator H would review advance directives with the residents upon their admission to the facility. After social service coordinator H would receive the resident's code status from the interview on admission she would document it in the resident's medical record. Within the first week of the resident's admission, medical director G would conduct an initial assessment of the resident and review the resident's advance directives with the resident.. Social service coordinator H would review the advance directive with the resident during the resident's care conference and make any changes that were needed. ED A stated that she completed the residents' admission paperwork when social service coordinator H when she was out of the facility. 8. Review of the provider's 12/22/14 Advance Directives policy revealed, "The Resident's attending physician will be notified of any Advance Directives and documentation of Advance Directives will be maintained in the Resident's permanent record and reviewed routinely or as needed."	F0578		
0684 S = D	Quality of Care CFR(s): 483.25	F0684		

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F0684 SS = D	Continued from page 3 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure quality of care for one of one samples resident (27) with hemiplegia (one-sided paralysis) who was not provided a pillow under her arm for support as indicated in her care plan by one of one certified nursing assistant (I). Observation and interview on 3/10/26 at 1:08 p.m. in resident 27's room revealed she was seated in her wheelchair watching television. Her call light was lying on the bed to her left and her left hand was resting in her lap. A sign on the wall behind the resident read, "Place a pillow under my left arm when I am up in the wheelchair Due to my Stroke". No pillow was positioned under resident 27's left arm. Resident 27 stated she was unsure when the staff had last placed a pillow under her left arm when she was seated in her wheelchair. 2. Observation on 3/11/26 at 1:30 p.m. revealed resident 27 was sitting in her wheelchair the commons area of the facility. Her left arm was positioned down between her left leg and the left armrest of her wheelchair. There was no pillow observed under her left arm. 3. Review of resident 27's electronic medical record revealed she admitted to the facility on 10/2/25. Her 1/8/26 Brief Interview for Mental Status score was 8, which indicated her cognition was moderately impaired. Her diagnoses included hemiplegia following cerebral infarction (paralysis of one side of the body caused by a stroke), and dementia (a group of symptoms affecting memory, thinking, and social abilities). Resident 27's 1/12/26 care plan under the section ADL (activities of daily living) Functional/Rehab Potential dated 1/12/26 indicated:" Please support my left arm with a pillow when I am sitting in my wheelchair."	F0684	In reference to F684, the care plan for resident was reviewed and updated to represent the need for pillow under arm due to resident condition. The EMAR was reviewed and updated by Clinical Care Coordinator to ensure pillow is placed under resident arm when in wheelchair. Nursing to sign off on EMAR every shift. The Director of Nursing, or designee, will conduct a random audit weekly of 3 residents for one month and then monthly for two months. Random audits will be conducted on care plans to ensure compliance with quality of care. Results will be reviewed by the QAPI committee for recommendations.	04/26/2026

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F0684 SS = D	Continued from page 4 4. Interview on 3/12/26 at 8:07 a.m. with certified nursing assistant (CNA) I in resident 27's room revealed she was aware of the sign posted in resident 27's room. CNA I stated that she believed she had placed the pillow under resident 27's arm on 3/11/26 but later acknowledged she had forgotten to do so. She further stated that the sign was provided by the therapy department and was posted in the room for a couple of months. 5. Interview on 3/12/26 at 8:13 a.m. with director of rehabilitation (DOR) J regarding discharging of a resident from therapy revealed that when a resident was discharged from therapy a Restorative Nursing Referral and Treatment Record form was completed. That form was then to be placed in the restorative binder so that the restorative nursing staff could continue those treatment interventions with the resident. 6. Interview on 3/12/26 at 8:20 a.m. with executive director (ED) A and interim director of nursing (IDON) B revealed minimum data set (MDS) coordinator K initiates the completed Restorative Nursing Referral and Treatment Record form received from the therapy department with the restorative nursing program. After restorative was completed then the MDS Coordinator would add the restorative task to the residents' care plan so the CNAs can begin implementing the new goal. 7. Interview on 3/12/26 at 8:25 a.m. with MDS coordinator K revealed she received resident 27's completed Restorative Nursing Referral and Treatment Record from the therapy department on 12/23/25 and implemented her restorative therapy. She added the restorative task to resident 27's care plan on 1/12/26 for the CNAs to implement. 8. Continued interview on 3/12/26 at 8:29 a.m. with ED A and DON B revealed that the task of placing a pillow under resident 27's left arm while she was in her wheelchair was not added to the resident's medication administration record (MAR) on 1/12/26, would would notify the CNAs to document that they had completed that task. ED A stated that when a new goal was added to a residents' care plan, it was highlighted in yellow to alert the CNAs of a new goal. ED A and DON B both expected the CNAs to follow the residents' care plan. 9. Interview on 3/12/26 at 9:45 a.m. with CNA I	F0684		

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F0684 SS = D	Continued from page 5 revealed that she confirmed that a new goal in the residents' care plan was highlighted in yellow to alert the CNAs to a change. 10. Review of the provider's 6/17/25 Care Plan policy revealed: "3. Each resident's comprehensive care plan is designed to:" "f. As appropriate and applicable, assist in prevention of decline or maintenance of current ability in resident's functional status and/or functional level;"	F0684		
F0880 SS = D	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;	F0880	In reference to F880, basin and catheter was removed from the room due to resident being admitted to hospital. Policy reviewed and remains appropriate. Clinical Care coordinators audited other resident rooms who have a catheter to ensure policy was being followed and found remaining catheters to be in compliance. Education will be provided to all nursing staff on catheter care policy on or before April 26, 2026 by Director of Nursing or designee. Hand hygiene policy reviewed and remains appropriate. Education in regards to feeding residents and hand hygiene to be provided to all nursing staff on or before April 26, 2026 by Director of Nursing or designee. The Director of Nursing or designee will conduct random audits of catheter storage compliance, observation of staff assisting residents to eat in dining room, and ensuring proper hand hygiene is used between residents to ensure policy is being followed. Audits will be conducted weekly for one month, then monthly for two months to ensure compliance. Results will be reviewed by the QAPI committee for recommendations.	04/26/2026

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F0880 SS = D	Continued from page 6 (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 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 observation, interview, record review, and policy review, the provider failed to ensure the staff followed standard infection prevention practices regarding urinary catheter (flexible tubing placed in the bladder to drain urine) care according to the provider's policy for one of one sampled resident (56) with her catheter supplies stores in a container on a shared bathroom floor, and lack of hand hygiene by two of two certified nursing assistants (D and F) observed assisting two of two sampled residents (15 and 19) with	F0880		

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F0880 SS = D	Continued from page 7 eating. Findings include: 1. Observation on 3/10/26 at 10:05 a.m. in resident 56's room revealed resident 56 was asleep in her bed and shared a bathroom with her roommate. The bathroom door was open and there was an unlabeled pink plastic container on the floor under the sink. That container held a bottle of liquid with the label distilled vinegar, an empty 60cc (cubic centimeter) syringe, and an unlabeled urinary catheter (flexible tubing placed in the bladder to drain urine) urine collection bag. The urine collection bag had a colorless liquid in it and there was no cap placed over the opening of the tubing. 2. Review of resident 56's electronic medical record (EHR) revealed she was admitted to the facility on 3/6/26. On 3/7/26 a nurse performed a bladder scan (a noninvasive imaging device that can read the amount of fluid that is in a bladder) and determined that resident 56 was retaining urine. A physician's order to place a urinary catheter was obtained and a nurse placed the urinary catheter. The resident was admitted to the hospital on 3/10/26 for conditions unrelated to that urinary catheter. 3. Observation on 3/11/26 at 11:08 a.m. revealed that the pink plastic container with urinary catheter supplies was still on the floor under the sink in resident 56's shared bathroom. 4. Interview on 3/11/26 at 3:11 p.m. with certified nurse assistant (CNA) E revealed each resident with a urinary catheter used a night urinary catheter bag and a day urinary catheter bag. The night bag was larger and could hang on the resident's bed so the staff could empty it without disturbing the resident while they slept. The day bag was smaller and attached to the resident's leg under their clothes for privacy. The CNAs were expected to change the day urinary catheter bags to the night urinary catheter bags. The CNA would remove one urinary catheter bag, clean the tubing with an alcohol wipe, and attach the other urinary catheter bag. The removed urinary catheter bag would be emptied and flushed with water. The CNA would then use a 60cc	F0880		

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F0880 SS = D	Continued from page 8 syringe to insert vinegar into that bag, place a cap over the tube to prevent vinegar from leaking out, and store the vinegar-filled bag in a pink plastic container in the resident's bathroom cabinet. CNA E acknowledged that resident 56's urinary catheter bag was not stored correctly because it did not have a cap on the tube and the pink plastic container was on a shared bathroom floor. 5. Interview on 3/11/26 at 3:20 with registered nurse (RN) C revealed the night shift was expected to change out all urinary catheter bags on Saturday nights. They would also be expected to obtain a new 60cc syringe and write the date on the syringe with a permanent marker. She agreed with CNA E that the catheter bag that was not in use by the resident was to be filled with distilled vinegar and stored in the resident's bathroom cabinet. She acknowledged that storing resident 56's urinary catheter bag in a pink plastic container on the floor in a bathroom shared between two residents increased the risk of it being contaminated. She then removed resident 56's urinary catheter supplies from the bathroom floor and disposed of them. 6. Observation on 3/10/25 at 11:24 a.m. in the main dining room revealed CNA F was sitting at a dining table between residents 15 and 19 for the noon meal. She assisted resident 19 to take a bite of food from a spoon that was in CNA F's right hand. She put the spoon down, turned to resident 15, grabbed resident 15's spoon with her right hand and fed resident 15 a bite of food. CNA F continued to assist residents 15 and 19 four more times without washing her hands before or after touching their eating utensil. 7. Observation on 3/10/26 at 4:40 p.m. in the main dining room revealed CNA D scooped up a bite of food onto a fork, fed that bite of food to resident 15 and placed the fork onto resident 15's plate. CNA D then turned to resident 19 and scooped up a bite of food onto her spoon, fed that food to resident 19 and placed the spoon down on resident 19's plate. CNA D did not wash or sanitize her hands before assisting residents 15 and 19 to eat.	F0880		

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F0880 SS = D	Continued from page 9 8. Interview on 3/12/26 at 11:45 a.m. with executive director A and interim director of nursing/infection preventionist B revealed they expected the staff to perform hand hygiene between assisting different residents. That expectation included when the staff assisted residents with eating, and when the staff members used the same hand between those residents. They expected staff members to follow the provider's policy for urinary catheter bag cleaning and storage. The pink plastic container with the urinary catheter cleaning supplies should be stored in the cabinet in the resident's bathroom. They expected the 60cc syringe to be dated, and the urinary catheter tubing to have a cap over the tip to keep the inside clean. They acknowledged that storing the urinary catheter cleaning supplies in the pink plastic container on the floor of a shared bathroom could compromise those supplies and they would no longer be considered clean. 9. Review of the provider's 3/16/16 Catheter Care policy revealed the catheter bags were to be cleaned daily. The procedure for cleaning the bag included instructions for the staff to empty the urine from the bag and then to "pour [an] adequate amount of cleaning solution consisting of one part vinegar to four parts water into a graduated cylinder. Using a large syringe, instill the solution into the tubing and allow [it] to flow into the bag. Rinse [the] solution around in [the] bag and tubing and allow to sit for a minimum of one hour. Empty [the] solution and store bag." "The syringe will be dated and changed on a weekly basis along with the day bag." The night urinary catheter bag would be changed "monthly unless specific [specified] differently by a physician." 10. Review of the provider's 4/13/20 Hand Hygiene policy revealed that hand hygiene was to be completed by the staff before assisting a resident to eat. 11. Review of the provider's 1/22/18 Assisted Dining Program Curriculum revealed that the staff were to perform hand hygiene "before and after each resident contact" and "between different residents when feeding."	F0880		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435033	A. BUILDING B. WING	03/10/2026

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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 3/10/26. Westhills Village Health Care Facility was found in compliance.	E0000		

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
Kelsey Bartsch	Executive Director	04/01/2026

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435033	A. BUILDING **01 - MAIN BUILDING 0...** B. WING	**03/10/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westhills Village Health Care Facility	**255 TEXAS ST , RAPID CITY, South Dakota, 57701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 3/10/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Westhills Village Health Care Facility was found in compliance.	K0000		

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
Kelsey Bertsch	Executive Director	04/01/2026

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
	10721	A. BUILDING: _____ B. WING _____	03/12/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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 3/10/26 through 3/12/26. Westhills Village Health Care Facility was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelsey Bertsch

TITLE: Executive Director

(X6) DATE: 04/01/2026