

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 65643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
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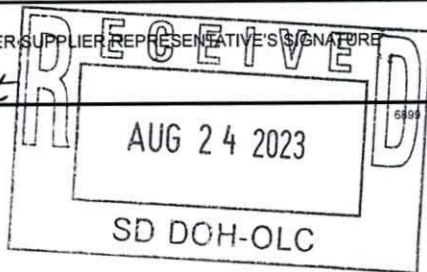
NAME OF PROVIDER OR SUPPLIER MEDICINE WHEEL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 24266 AIRPORT ROAD POST OFFICE BOX 800 EAGLE BUTTE, SD 57625
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Compliance Statement</p> <p>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 8/1/23 through 8/3/23. Medicine Wheel Village was found in compliance.</p>	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Deb Arbogast

STATE FORM



TITLE

Licensed Nursing Facility Administrator

(X6) DATE

8/23/2023

ICBB11

If continuation sheet 1 of 1