| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 43A138 | A. BUILDING<br>B. WING | 09/01/2026 |

| 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 |
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| E0000 | Initial Comments<br><br>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 9/1/26. Medicine Wheel Village 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 |
|---|---|---|
| Angela M. Turner, LNHA | NHA | 9-25-26 |

| 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 09/03/2026 |
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| F0000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/1/26 through 9/3/26. Medicine Wheel Village was found not in compliance with the following requirements: F552, F658, F686, F880, and F887. | F0000 | | 10-2-26 |
| F0552<br>SS = E | Right to be Informed/Make Treatment Decisions<br><br>CFR(s): 483.10(c)(1)(4)(5)<br><br>§483.10(c) Planning and Implementing Care.<br><br>The resident has the right to be informed of, and participate in, his or her treatment, including:<br><br>§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.<br><br>§483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.<br><br>§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, interview, and policy review, the provider failed to ensure the residents or their representatives gave consent for the use of psychotropic (drugs that affect brain activities associate with mental processes and behavior) medications for three of four sampled residents (2, 7, and 21) who were administered psychotropic medications. | F0552 | 1/ Residents/Resident representatives for residents 2,7,and 21 were provided with psychotropic consent forms by the DON/Designee. Consents for the administration of psychoactive medication were signed for all 3 residents.<br><br>2/ An audit of the medical records of all residents receiving psychotropic medications was completed by the Social Worker/Designee' on 9-28-26. Any residents/resident representatives were provided consent forms by the SW/Designee, and signed off their consent for the administration of psychotropic medications.<br><br>3/ The facility policy on the Use of Psychotropic medications, including the need for the use of consent forms was reviewed in an Ad-hoc QAPI Meeting by the NHA and approved as written by the QAPI Committee. The Social worker and licensed nurses received education on the facility policy on Psy-\chotropic use by the NHA/Designee 9-22; 9-23; 9-28.<br><br>4. 25% of all resident records were reviewed by the DON/Designee weeklyx 4 and monthly thereafter for 3 months. Results were brough to QAPI Mtg to verify compliance.NHA responsible for ongoing compliance. | |

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.

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| Angela M. Turner | NHA | 9-25-26 |

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| F0552 SS = E | Continued from page 1<br>Findings include:<br><br>1.Review of resident 2's electronic medical record (EMR) revealed she admitted to the facility on 1/8/26. Her 4/10/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had a diagnosis of depression.<br><br>She had a 4/4/26 physician's order to be given one capsule of Cymbalta (a psychotropic medication that treat depression) 60 milligrams once a day. No documentation indicated that her consent for that medication was given. Review of her medication administration record (MAR) revealed she received her Cymbalta from 4/26 through 8/26 daily.<br><br>Interview on 9/3/26 at 10:45 a.m. with director of nursing (DON) B revealed resident 2 had not signed the consent to the Cymbalta on 7/24/26 when the informed consent for the Cymbalta was filled out.<br><br>2. Review of resident 7's EMR revealed she admitted to the facility on 5/15/2019. Her 7/11/26 BIMS assessment score was 5, which indicated that her cognition was severely impaired. She had diagnoses of dementia (a group of symptoms affecting memory, thinking, and social abilities) and anxiety. She had a 2/8/26 physician's order to be given a half tablet of Quetiapine (an antipsychotic medication that helps balance chemicals in the brain) 25 milligrams twice a day. She also had a 8/29/26 physician's order to be given one capsule of Fluoxetine (a psychotropic medication used to treat depression and anxiety) 20 milligrams once a day. No documentation indicated that her consent for both medications was given.<br><br>3. Review of resident 21's EMR revealed that she admitted to the facility on 11/20/24. Her 9/4/26 BIMS assessment score was 00, which indicated that her cognition was severely impaired. She had diagnoses of dementia and anxiety. She had a 7/10/25 physician's order to be given one capsule of Fluoxetine 20 milligrams once a day, a 2/2/26 physician's order to be given one tablet of Remeron (a psychotropic medication used to treat depression) 30 milligrams once a day, and a 2/2/26 physician's order to be given two capsules of Depakote (a psychotropic medication used to stabilize mood) 125 milligrams twice per day. No documentation indicated that her consent for the Depakote medication was given.<br><br>4. Interview and record review on 9/2/26 at 1:22 p.m. with DON B revealed that the formerly | F0552 | | |

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| F0552 SS = E | Continued from page 2<br>employed Minimum Data Set (MDS) nurse, was responsible for obtaining informed consents for antipsychotic medication use from the residents or their representatives. That responsibility would belong to social services designee (SSD) F.<br><br>DON B stated that if a resident's psychotropic medication use consent was not signed by the resident or their representative, or if a conversation occurred regarding consent for a psychotropic medication but it was not documented, then she did not think the resident provide their consent for use of that medication.<br><br>DON B reviewed resident 7's and resident 21's psychotropic medication informed consents and agreed that they were not signed. She had no way of knowing if the resident or their representative was informed of the medication, risks, benefits, alternatives, or which staff member completed those forms. She confirmed that resident 21 did not consent to receive Depakote (a medication used to stabilize mood or to control seizures) medication since it was initiated on 2/2/26.<br><br>5. Interview on 9/2/26 at 1:55 p.m. with SSD F revealed that he was recently assigned responsibility for that process of obtaining psychotropic medication consents for residents. He stated that he did not a consider consent as completed without the resident or their representative's signature.<br><br>6. Review of the provider's undated Use of Psychotropic Medication policy revealed that before initiating or increasing a psychotropic medication, the resident or resident representative must be informed of the benefits, risks, and alternatives for the medication. The resident or resident representative could then accept or decline the psychotropic medication, and the facility would document that decision. | F0552 | | |
| F0887 SS = E | COVID-19 Immunization<br><br>CFR(s): 483.80(d)(3)(i)-(vii)<br><br>§483.80 Infection control<br><br>§483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: | F0887 | | |

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| F0887 SS = E | Continued from page 3<br>(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;<br><br>(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;<br><br>(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;<br><br>(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses.<br><br>(v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and<br><br>(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:<br><br>(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and<br><br>(B) Each dose of COVID-19 vaccine administered to the resident, or<br><br>(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal.<br><br>(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:<br><br>(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;<br><br>(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and<br><br>(C) The COVID-19 vaccine status of staff and related | F0887 | 1/ Residents 4,11,24, and 27 were offered the Covid vaccine upon its next availability by the IP/DON/ Designee 9-23; 9-24; and 9-28.<br><br>2/ All resident medical records were reviewed for the presence of an updated COVID vaccine signed con sent/declination on 9-22; 9-23; and 9-28 by the IP and or DON/Designee. Any missing consent/dec- lination forms were replaced with a current, signed form by the DON/IP/Designee. The COVID Vaccine will be administered to those residents that want it as soon as it becomes available by the IP/DON.<br><br>3/ The COVID19 Vaccination Policy was brought to the QAPI Committee by the NHA and approved by the QAPI Committee on 9-23-26. The COVID 19 Vaccination Policy was reviewed with all of the nur- sing staff by the IP/DON/NHA. All resident records were updated to include Covid 19 consent/declina- tion forms on 9-22; 9-23; 9-28 by the IP/DON/Desig- nee.<br><br>4/ 25% of resident records will be audited for up- dated COVID 19 consents/declinations weekly for 4 weeks and monthly for 3 months. All results will be brought to the QAPI Committee Meeting by the DON to verify compliance.<br><br>The NHA is responsible for ongoing compliance. | 10-2-26 |

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| F0887 SS = E | Continued from page 4<br>information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, interview, and policy review, the provider failed to ensure that the residents received or were offered the annual 2025 COVID-19 vaccination for four of five sampled residents (4, 11, 24, and 27) without documentation that indication that vaccination was given to them or was offered or refused.<br><br>Findings include:<br><br>1.Review of resident 4's electronic medical record (EMR) revealed she admitted to the facility on 8/2/23. She received the COVID-19 Booster on 11/20/24. There was no documentation that she was given, offered or refused the annual 2025 COVID-19 vaccination.<br><br>2. Review of resident 11's EMR revealed he admitted to the facility on 4/16/24. He received the COVID-19 Booster on 11/20/24. There was no documentation that he was given, offered or refused the annual 2025 COVID-19 vaccination.<br><br>3. Review of resident 24's EMR revealed she admitted to the facility on 2/4/25. She received the COVID-19 Booser on 10/4/24. There was no documentation that she was given, offered or refused the annual 2025 COVID-19 vaccination.<br><br>4. Review of resident 27's EMR revealed he admitted to the facility on 12/6/24. He received the COVID-19 Booster on 6/29/22. There was no documentation that he was given, offered or refused the annual 2025 COVID-19 vaccination.<br><br>5. Interview on 9/3/26 at 8:30 a.m. with director of nursing (DON) B revealed the local hospital sets up a yearly clinic at the facility and their medical director will educated the residents on the COVID-19 vaccination. And the local hospital was responsible for administering the residents with their annual COVID-19 vaccination. She stated that in 2025, the hospital staff were to go to the facility to administer those vaccination but did not. After the local hospital staff did not show up, she contacted the backup | F0887 | | |

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| F0887 SS = E | Continued from page 5<br>health program to provide the 2025 COVID-19 vaccinations, but they also did not show up. She stated some of the residents were able to receive their annual 2025 vaccinations during dialysis appointments.<br><br>6. Review of the provider's undated COVID-19 Vaccination policy revealed, "The facility will educate and offer the COVID-19 vaccine to residents, resident representatives and staff and maintain documentation of such."<br><br>"COVID-19 vaccination will be offered to residents when supplies are available, as per CDC [Center for Disease Control and Prevention] and/or FDA [Food and Drug Administration] guidelines unless such immunizations is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine." | F0887 | | |
| F0658 SS = D | Services Provided Meet Professional Standards<br><br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, the provider failed to ensure that professional standards of nursing were followed by one of one director of nursing (DON) B who inaccurately entered physician's orders for semaglutide, an injection medication used to manage diabetes (a condition involving disruptions in how the body regulates blood sugar) for one sampled resident (5) who subsequently did not receive that medication as ordered by the physician between 2/1/26 through 9/2/26. Findings include:<br><br>1. Review of resident 5's EMR revealed he admitted to the facility on 7/6/25. He had a diagnosis of diabetes. He had physician orders for the following diabetic medications and intervention: a 0.5 mg [milligram] semaglutide injection every Friday (order start date 6/6/25), metformin, 500 mg, two tablets daily (start date 2/1/26), blood sugar checks PRN (as needed) with symptoms (dizzy, shaky, sweaty, or unusual thirst) (order start date 2/1/26). | F0658 | 1/ Resident 5s order for semaglutide was updated per his physician's order. The Regional Nurse Consultant reviewed the Policy of Physician Order Entry ( including second nurse verification) with the Director of Nursing on 9-30-26<br><br>2/ An audit of resident orders back to the survey exit date of 9-3-26 was completed by the DON/Designee on 9-24,9-28,and 9-30. Any order transcription errors were corrected as needed by the DON/Designee.<br><br>3/ The Policy/process for Physician Order Entry( include second nurse verification) was brought to the QAPI Committee by the NHA and deemed appropriate on 9-23-26. Licensed nursing staff on all shifts were educated on the Policy/Process for Order Entry (to include second nurse verification) by the DON/NHA/ Designee on 9-22;9-23;and 9-28.<br><br>4/ 25% or physician's orders will be audited by the DON foraccurate entry and second nurse verification weekly for4 weeks and monthly 3 months. Results will bebrought to the QAPI Committee by the DON to ensure compliance.<br><br>The NHA is responsible for ongoing compliance. | 10-2-26 |

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| F0658 SS = D | Continued from page 6<br>Resident 5's January 2026 Active Medication Orders Summary Report included an order for semaglutide, 0.5 mg (milligram) to be injected every Friday. The order date for that medication was 6/5/26, and the start date for that medication was 6/6/25. That Summary Report was signed as reviewed by the resident's physician and DON B on 1/26/26. There were no Active Medication Orders Summary Reports in the resident's EMR for February 2026 or March 2026. The April 2026 Active Medication Orders Summary Report revealed that the semaglutide injection order date was changed to 2/1/26, and the start date was changed to 2/5/27. That report was signed by DON B indicating it was reviewed and discussed with the resident's physician, but it was not dated. All subsequent 2026 monthly Active Medication Orders Summary Reports reflected a 2/1/26 order date and a 2/5/27 start date for the semaglutide injection.<br><br>Resident 5's January 2026 treatment administration records (TAR) indicated that he was administered a semaglutide injection every Friday of that month. His February 2026 TAR indicated that on 2/1/26, the semaglutide order was discontinued, and resident 5 did not receive semaglutide injections during that month. The semaglutide order was not on the resident's monthly TARs from March 2026 through September 2026.<br><br>Resident 5's June 2026, July 2026, and August 2026 TARs indicated that the resident did not require PRN blood sugar checks during those months.<br><br>A 7/22/26 physician's progress note indicated, "He [resident 5] is on the Metformin and Ozempic (semaglutide brand name) for his DM [diabetes mellitus]."<br><br>2. Interview on 9/2/26 at 1:45 p.m. with licensed practical nurse (LPN) G regarding the process for entering physicians' orders in the residents' EMR system revealed that the night shift nurse used to enter physicians' orders in a resident's EMR, and the day shift nurse used to double-check those orders for accuracy, but now only DON B entered physicians' orders in the residents' EMRs. They no longer had another nurse double-check the orders that DON B entered.<br><br>3. Interview and review of resident 5's EMR on 9/3/26 at 10:00 a.m. with DON B revealed that on 2/1/26, she entered the physician's order that discontinued resident 5's semaglutide injection and entered an order that restarted the semaglutide injection with a start date of 2/5/27. DON B | F0658 | | |

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| F0658 SS = D | Continued from page 7<br>acknowledged that the correct start date for the semuglutide injection should have been 2/5/26. That entry error removed the semaglutide injection order from the resident's monthly TARs, and resident 5 was no longer being administered the weekly semaglutide injection. That was a medication error. She was not aware of the error until it was brought to her attention during the interview. She notified resident 5's physician of the error on 9/3/26.<br><br>DON B stated that resident 5 had no known harm from not receiving that medication, based on the resident not requiring PRN blood sugar checks, changes to his Metformin medication, or having abnormal results on his 8/10/26 hemoglobin A1C test (a blood test that measures the average blood sugar levels over the past two to three months), but there was potential for harm to have occurred. She confirmed they no longer had a nurse double-check physician's orders entered into the EMR system to ensure accuracy.<br><br>4. Policies regarding physician order entry and following physicians' orders were requested from administrator A on 9/2/26 at 2:45 p.m. None were provided to the survey team to review before the survey exit. | F0658 | 1/ RN Nurse D was educated 1:1 by the DON on appropriate wound care as ordered by the physician on 9-4-26.<br><br>2/ All licensed nurses were observed and checked off on appropriate wound care as ordered by the physician by the DON/Designee 'on 9-24; 9-28; and 9-30. Any errors were noted and corrected.<br><br>3/ The Procedure for Wound Care as ordered by the Physician was brought to the QAPI Committee by the NHA, reviewed by the QAPI Committee and deemed appropriate on 9-24-26. Licensed nursing staff on all shifts were educated on the procedure for Wound Care as Ordered by the Physician by the DON/Designee' on 9-22 9-23; and 9-28.<br><br>4/ 25% of resident wound care treatments completed by licensed nursing personnel will be observed for compliance with facility Procedure for Wound Care as ordered by the Physician, weekly for 4 weeks and monthly for 3 months. Results will be brought to the QAPI Committee by the DON for verification of Compliance.<br>The NHA is responsible for ongoing compliance. | 10-2-26 |
| F0686 SS = D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br><br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br><br>§483.25(b)(1) Pressure ulcers.<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br><br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and policy review, the provider failed to ensure one of one registered nurse (RN) D provided pressure ulcer | F0686 | | |

| 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 09/03/2026 |
|---|---|---|---|

| 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 |
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| F0686 SS = D | Continued from page 8<br>(skin and/or underlying tissue injury due to prolonged pressure) care as ordered by the physician for one of one sampled resident (6) and one of one director of nursing (DON) B accurately entered a physician's order for a nutritional supplement for one of one sampled resident (6) who subsequently did not receive that supplement and admitted to the facility with an existing stage IV (4; open wound with full-thickness skin and tissue loss. Bone, tendon, or muscle may be visible.) pressure ulcer on her buttock.<br><br>Findings include:<br><br>1. Observation and interview on 9/1/26 at 12:35 p.m. in resident 6's room with resident 6 revealed that she was lying in bed on top of a pressure-reducing mattress. She admitted to the facility several months ago with a pressure ulcer on her buttock. She thought the pressure ulcer was healing.<br><br>2. Review of resident 6's electronic medical record (EMR) revealed she was admitted to the facility on 2/12/26. Her 5/22/26 Brief Interview of Mental Status (BIMS) assessment score was 14, indicating she had no cognitive impairment. A 2/18/26 skin note indicated that the resident had a stage IV pressure ulcer on her buttock. It measured 4 centimeters (cm) long, 6 cm wide, and 6 cm deep. An 8/27/26 skin note indicated the pressure ulcer measurements were 2.59 cm long, 1.66 cm wide, and 3.10 cm deep. Those wound measurement changes indicated that the wound had healing progress.<br><br>There was a 2/26/26 physician's order for the resident to receive Arginaid powder (a nutritional drink mix used to support wound and pressure injury healing) mixed with water two times a day.<br><br>The resident's 6/11/26 physician-ordered wound instructions indicated the staff were to cleanse the wound with normal saline (a sterile solution) and gently dry the wound bed with a clean 4-inch x (by) 4-inch (4X4) pad. Apply Wound Vashe (a solution used to clean, moisten, and debride [the removal of dead, damaged, or infected skin tissue] wounds) to another clean 4x4 pad and place it into the wound bed, allowing it to sit for 1 to 2 minutes before removing it. Cut Calcium Alginate (an absorbent medical dressing that turns into a soft gel upon contact with wound fluid) into strips and pack the wound bed lightly, covering the wound with a foam dressing. That wound care was ordered to be completed daily and PRN (as needed).<br><br>3. Observation, EMR review, and interview on 9/1/26 | F0686 | The NHA is responsible for ongoing compliance. | |

| 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 09/03/2026 |
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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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| F0686 SS = D | Continued from page 9<br>at 2:30 p.m. and at 4:20 p.m. with RN D during and after she completed wound care for resident 6's stage IV pressure ulcer revealed that RN D removed the existing foam dressing from resident 6's skin, cleansed the resident's wound with normal saline, and dried the resident's skin with a clean 4X4 pad. RN D then placed pre-cut strips of the Calcium Alginate inside the resident's wound bed, and covered the wound with a clean foam dressing.<br><br>RN D stated, "I've always done it [resident 6's wound care] like that." She indicated, "I don't know what that [Wound Vashe] is." She acknowledged that she did not complete resident 6's wound care according to the physician's order.<br><br>RN D stated that in the past, resident 6 was administered Arginaid to promote wound healing, but that order must have been discontinued because it was not an active physician's order on the resident's medication administration record (MAR) or treatment administration record (TAR).<br><br>4. EMR review and interview on 9/2/26 at 3:50 p.m. with director of nursing (DON) B regarding the above wound care observation revealed that RN D was expected to review resident 6's wound care orders before she completed the resident's wound care to ensure that it was completed as ordered by the physician. DON B confirmed that there was no documentation to support that resident 6 was receiving Arginaid powder twice a day as ordered. DON B entered the 2/26/26 Arginaid order into resident 6's EMR, but she did not select the correct "Order Type" that would have transferred the order to the resident's MAR to allow its administration to be documented by the nursing staff. As a result, resident 6 was not receiving her physician-ordered nutritional supplement twice daily. DON B thought that resident 6's buttock pressure ulcer exhibited signs of healing, but she stated it was possible that the healing may have progressed more quickly if the above physician orders were provided as ordered. 5. Review of the provider's undated Wound Treatment Management policy revealed, "1. Wound treatments will be provided in accordance with physician orders..."<br><br>6. Review of the provider's undated Pressure Injury Prevention and Management policy revealed that evidence-based interventions will be implemented to prevent and promote wound healing. That included maintaining or improving the resident's nutritional status. | F0686 | | |

| 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 09/03/2026 |
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| **Medicine Wheel Village** | **24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 57625** |

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| F0880 SS = D | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br><br>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.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must | F0880 | 1/ Nurse D received 1:1 education from the DON on handwashing and glove use on 8-31 26. Resident 6 was verified to have an uninfected wound on 9-4-26 by the DON/Des ignee.<br><br>2/ All nurses were checked off for appropriate wound treatment technique, including hand-washing and glove use by the DON/Designe on 9-22; 9-23, and 9-28. Any nurses with concerns as to handwashing and glove use were immediately retrained by the DON/Desi ignee. All residents who receive wound care were re-checked for infection on 9-28 by the DON/Designee. No new concerns were found.<br><br>3/ The policy and procedure for handwashing and glove handling was brought to the QAPI Committee by the NHA and deemed approp riate on 9-24-26. Staff on all shifts were in-serviced by the DON/IP/Designee on 9-22: 9-23; and 9-28.<br><br>4/ 25% of wound treatments completed by licensed nursing staff will be audited by the DON/IP weekly for 4 weeks and monthly for 3 months. Results will be brought to QAPI Committee by the DON/Designee for verifica tion of compliance.<br><br>The NHA is responsible for ongoing compliance. | 10-2-26 |

| 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 09/03/2026 |
|---|---|---|---|

| 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 |
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| F0880 SS = D | Continued from page 11<br>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<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview, observation, record review, and policy review, the provider failed to ensure the staff followed infection prevention and control practices for hand hygiene (HH) (handwashing with soap and water or the use of an alcohol-based hand sanitizer [ABHS]) and glove use by one of one registered nurse (RN) (D) observed while providing wound care for one of one sampled resident (6) with a pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) on her buttock.<br><br>Findings include:<br><br>1. Interview on 9/1/26 at 11:25 a.m. with RN D regarding resident 6 revealed that the nurse changed the dressing on the resident's pressure ulcer earlier that morning, after the resident had diarrhea. The dressing was scheduled to be changed daily and PRN (as needed). RN D thought that the pressure ulcer was present when the resident admitted to the facility.<br><br>2. Observation and interview on 9/1/26 at 12:35 p.m. with resident 6 in her room revealed she was lying in bed on a pressure-reducing mattress. She stated that the ulcer on her buttock developed before she admitted to the nursing home. She thought that the ulcer was healing. | 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 09/03/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **Medicine Wheel Village** | **24266 AIRPORT ROAD PO BOX 880, EAGLE BUTTE, South Dakota, 57625** |

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| F0880 SS = D | Continued from page 12<br>3. Review of resident 6's electronic medical record (EMR) revealed she was admitted to the facility on 2/12/26. Her 5/22/26 Brief Interview of Mental Status (BIMS) assessment score was 14, indicating she had no cognitive impairment. A 2/18/26 skin note indicated that the resident had a stage IV (4; open wound with full-thickness skin and tissue loss. Bone, tendon, or muscle may be visible.) pressure ulcer on her buttock. Review of resident 6's February 2026 through August 2026 skin notes that contained ongoing measurements of the resident's buttock ulcer, indicated that the wound had healing progress.<br><br>4. Observation and interview on 9/1/26 at 2:30 p.m. of RN D in resident 6's room revealed that she performed hand hygiene and put on a gown and a clean pair of gloves before she initiated the resident's wound care. She removed the existing foam bandage from the resident's buttock, cleansed the wound with normal saline, and patted it dry with a clean 4-inch by 4-inch pad. RN D then lightly packed the wound bed opening with pre-cut strips of Calcium Alginate (a highly absorbent medical dressing that turns into a soft gel upon contacting wound fluid). She covered the wound bed with a foam bandage. RN D removed her soiled gloves and gown, discarded them in the trash can, and performed hand hygiene.<br><br>RN D acknowledged that she did not, but should have, taken off and discarded her gloves, performed hand hygiene, and put on a pair of clean gloves after she had removed the soiled bandage from the resident's buttock. She should have removed and discarded her soiled gloves, performed hand hygiene, and put on a pair of clean gloves after cleaning the resident's wound, and before she packed it with the Calcium Alginate strips, but she did not.<br><br>5. Interview on 9/2/26 at 3:50 p.m. with director of nursing (DON) B regarding the above observation revealed that RN D's failure to remove and discard her gloves, wash her hands, and put on clean gloves at those specific times during the completion of resident 6's wound care increased the resident's potential risk for infection and/or cross-contamination.<br><br>6. Review of the provider's undated Clean Dressing Change policy revealed, "9. Loosen the tape and remove the existing dressing." "10. Remove gloves." "11. Wash hands and put on clean gloves." "12. Cleanse the wound as ordered. Pat dry with gauze." "14. Wash hands and put on clean gloves." | F0880 | | |

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 _____ | 09/03/2026 |

| 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 |
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| S 000 | Compliance/Noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/1/26 through 9/3/26. Medicine Wheel Village was found not in compliance with the following requirement: S236. | S 000 | | |
| S 236 | 44:73:04:12(1) Tuberculin Screening Requirements<br><br>Tuberculin screening requirements for healthcare personnel or residents are as follows:<br>(1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous | S 236 | 1/ Residents 1,2,6, and 8 received up dated T.B. tests 2 step as administered by the DON/IP/Designee on 9-24;9-25.<br><br>2/ All resident records were audited by the DON/Designee. Any resident lacking a record of state compliant tb testing received a 2-step tb. test on 9-30;10-1 from the DON/Designee.<br><br>3/ The facility policy on resident tb test ing was brought to the QAPI Committee by the NHA and deemed appropriate on 9-24-26.<br>All Admissions and Clinical Staff were trained on the t.b. testing requirements for all South Dakota Nursing Homes by the DON/Designee on 9-22;9-23; and 9-28.<br>This is encompassed in the facility t.b.testing requirements.<br><br>4/ 25% of resident records will be audited weekly by the DON/Designee weekly for 4 weeks and monthly for 3 months. Results will be brought to the QAPI meet-ing by the DON/Designee to verify comp iance.<br><br>The NHA is responsible for ongoing compliance. | 10-2-26 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| 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 _____ | 09/03/2026 |

| 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 |
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| S 236 | Continued From page 1<br>positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on record review, interview, and policy review, the provider failed to ensure four of five sampled residents (1, 2, 6, and 8) completed a tuberculin (TB) (a serious infection that primarily affects the lungs and is spread through the air by coughs and sneezes) two-step skin test or blood assay test within 21 days of admission to the facility, or had documentation of a negative TB test in the 12 months before their admission to the facility.<br><br>Findings include:<br><br>1. Review of resident 1's electronic medical record (EMR) revealed she admitted to the facility on 8/13/26. Her two-step TB skin tests were documented as completed on 1/10/23 and 1/27/23. There was no other TB skin testing documentation in her EMR.<br><br>2. Review of resident 2's EMR revealed she admitted to the facility on 1/28/26. Her two-step TB skin tests were completed on 6/18/26 and on 6/30/26.<br><br>3. Review of resident 6's EMR revealed she admitted to the facility on 2/12/26. Her two-step TB skin tests were completed on 6/18/26 and on 6/30/26.<br><br>4. Review of resident 8's EMR revealed she | S 236 | | |

| 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 _____ | 09/03/2026 |

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

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| S 236 | Continued From page 2<br>admitted to the facility on 8/6/26. The first step of her two-step TB skin test was completed on 6/18/25. There was no other TB skin testing documentation in her EMR.<br><br>5. Interview on 9/2/26 at 10:00 a.m. with director of nursing (DON) B and infection preventionist/registered nurse (IP/RN) C who participated by telephone revealed that in May 2026, IP/RN C assumed responsibility for ensuring all residents' TB skin tests were completed within the expected timeframe and documented in their EMR. IP/RN C was currently on leave.<br><br>Review of the above residents' TB skin test documentation with DON B revealed that she acknowledged those EMR findings regarding residents 1, 2, 6, and 8's TB skin tests documentation.<br><br>6. Review of the provider's undated Resident Screening for Tuberculosis policy revealed, "Prior to or at the time of admission, all new residents will receive TB screening and testing and/or chest radiograph [x-ray] in accordance with state requirements." | S 236 | | |

| 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 **09/01/2026** |
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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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| K0000 Bldg. 01 | INITIAL COMMENTS<br><br>A recertification survey was conducted on 9/1/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Medicine Wheel Village 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 |
|---|---|---|
| Angela M. Turner, LNHA | NHA | 9-25-26 |