STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A138	A. BUILDING _____ B. WING _____	C 02/28/2020

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) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 40788 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/26/20 through 2/28/20. Medicine Wheel Village was found not in compliance with the following requirements: F576, F578, F658, F660, F700, F732, and F909. A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/26/20 through 2/28/20. Areas surveyed included admission, transfer, and discharge rights. Medicine Wheel Village was found not in compliance with the following requirements: F624.	F 000		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail.	F 576		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deb Arbogast
TITLE: Nursing Facility Administrator
(X6) DATE: 3/18/2020

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

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F 576	Continued From page 1 §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on interview and policy review, the provider failed to ensure mail delivery was available on Saturday for all residents. Findings include: 1. Resident group interview on 2/26/20 at 2:30 p.m. revealed: *There was no mail delivered on Saturday. *The residents were unaware they could have mail delivered on Saturday. *The residents wanted their mail delivered on Saturday. Interview on 2/28/20 at 10:48 a.m. with administrator A revealed:	F 576	All Medicine Wheel Village employees will be educated **by administrator** to assure residents receive mail delivery according to federal postal mail delivery dates and or 6 days per week by March 24th,2020. The Activities Director or designee will audit daily mail delivery form weekly to assure mail is being delivered 6 days per week **by the Activity Department staff members** according to Postal delivery and report to QAPI monthly times 6 months. **3/25/2020 D.A.**	3/24/2020

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F 576	Continued From page 2 *There was no mail delivered to the residents on Saturday. *The mail was available at the post office, but no one went and picked it up on the weekend. *She agreed the residents should have their Saturday mail delivered to them. Review of the provider's May 2017 Mail and Electronic Communication policy revealed: "Mail and packages will be delivered to the resident within twenty-four hours (24) of delivery on premises or the facility's post office box (including Saturday deliveries)."	F 576		
F 578 SS=E	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.	F 578		

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F 578	Continued From page 3 (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 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: Surveyor: 40788 Based on record review, interview, and policy review, the provider failed to ensure seven of nine sampled residents' (5, 6, 9, 11, 16, 18, and 19) advance directives had been: *Completed upon admission. *Communicated to their physician in a timely manner. *Periodically reviewed with the resident and the resident's representative. Findings include: 1. Review of resident 16's medical record revealed: *His admission date was 1/29/19. *His advance directive was signed by his legal representative on 2/28/19. *His physician had signed that advance directive on 1/22/20. *There was no documentation that indicated the	F 578	Education for Social Services Designee, DON, all RN/LPN **by Administrator** will be completed by March 24th , 2020 on Advance Directives. Advance Directives **will** be completed upon admission along with communication to physician in a timely manner. Advance Directive status will be reviewed at each Care Conference. Advance Directive status Has been added to each resident Point Click Care face sheet. Social Services or designee will audit all new admissions **and current residents for completion of Advance Directive** status , timely communication to physician. **Advance Directive status audit to be completed weekly times 12 weeks and monthly times 6 months and report to QAPI. 3/25/2020 D.A.** Resident 16 Advance directive is signed and on Point Click Care Face Sheet.and will be reviewed at each care conference with resident and or health care guardian.	3/24/2020 3/24/2020

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F 578	Continued From page 4 advance directive had been periodically reviewed with his legal representative. 2. Review of resident 18's medical record revealed: *Her admission date was 1/28/19. *Her advance directive was dated 12/20/16. -That advance directive was completed at the nursing home where she had previously resided. *A new advance directive was not completed and signed by her new healthcare provider after she admitted to the facility on 1/28/19. 3. Review of resident 19's medical record revealed: *His admission date was 7/25/19. *His advance directive was signed by his legal representative on 7/30/19. *His physician had signed that advance directive on 1/22/20. *There was no documentation that indicated the advance directive had been periodically reviewed with his legal representative. Surveyor: 29162 4. Review of resident 5's medical record revealed: *His admission date was 1/29/19. *His advance directive was signed by his legal representative on 2/28/19. *His physician had signed that advance directive on 1/22/20. *There was no documentation that indicated the advance directive had been periodically reviewed with his legal representative. 5. Review of resident 6's medical record revealed:	F 578	Resident 18 Advance directive is signed and on Point Click Care Face Sheet.and will be reviewed at each care conference with resident and or health care guardian. Resident 19 Advance directive is signed and on Point Click Care Face Sheet.and will be reviewed at each care conference with resident and or health care guardian. Resident 5 Advance directive is signed and on Point Click Care Face Sheet.and will be reviewed at each care conference with resident and or health care guardian. Resident 6 Advance directive is signed and on Point Click Care Face Sheet.and will be reviewed at each care conference with resident and or health care guardian.	3/24/2020 3/24/2020 3/24/2020 3/24/2020

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F 578	Continued From page 5 *His admission date was 5/2/19. *The resident had signed her advance directive on 5/2/19. *Her physician had signed that advance directive on 1/22/20. *There was no documentation that indicated the advance directive had been periodically reviewed with the resident. 6. Review of resident 9's medical record revealed: *Her admission date was 4/8/19. *She had signed her advance directive on 4/8/19. *Her physician had signed that advance directive on 1/22/20. *There was no documentation that indicated the advance directive had been periodically reviewed with the resident. 7. Review of resident 11's medical record revealed: *Her admission date was 7/25/19. *Her advance directive had been signed by her guardian but not dated. *Her physician had signed that advance directive on 1/22/20. *There was no documentation that indicated the advance directive had been periodically reviewed with her guardian. Interview on 2/27/20 at 2:59 p.m. with social services designee I regarding advanced directives revealed: *She had not obtained advanced directives for the above residents at the time of admission. *Often during admission the resident would tell her to ask their family. *The residents told her that even when they did not have a durable power of attorney (DPOA) or	F 578	Resident 9 Advance directive is signed and on Point Click Care Face Sheet.and will be reviewed at each care conference with resident and or health care guardian. Resident 11 Advance directive is signed and on Point Click Care Face Sheet.and will be reviewed at each care conference with resident and or health care guardian.	3/24/2020 3/24/2020

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F 578	Continued From page 6 guardian. *She had been days-to-months behind in obtaining the residents' advanced directives. *The resident's family would not assist with the advanced directive request. *She tried to call the families to have them come in and fill out the advanced directives for the residents. -Often they did not answer the phone or call her back. *She had not documented those attempted phone calls. *She had not tried mailing the forms to be signed to families or DPOAs. Interview on 2/28/20 at 9:45 a.m. with administrator A confirmed the above findings. She stated they hoped to implement a new process soon. Review of the provider's last revised December 2016 Advance Directive policy revealed: *"Advance directives will be respected in accordance with state law and facility policy." *"6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives." *"8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. -a. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. -b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance."	F 578		

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F 578	Continued From page 7 *"9. The Attending Physician will provide information to the resident and legal representative regarding the resident's health status, treatment options and expected outcomes during the development of the initial comprehensive assessment and care plan." *"18. The Interdisciplinary Team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such review will be made during the annual assessment process and recorded on the resident assessment instrument (MDS) [Minimum Data Set assessment]." *"20. The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care."	F 578		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on interview, closed record review, and policy review, the provider failed to provide and document preparation to ensure a safe and orderly transfer for three of three sampled residents (12, 21, and 38) who had been transferred from the facility to an emergency	F 624		

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F 624	Continued From page 8 room. Findings include: 1. Review of resident 12's closed medical record revealed: *Nurse progress notes indicated she had labored breathing and low oxygen saturation. -The DON was notified as well as the resident's family. *A nursing progress note dated 2/26/20 at 8:21 a.m. read: "Ambulance here and to ER [emergency room]. Papers sent with." *A nursing progress note dated 2/26/20 at 10:02 a.m. that stated the hospital nurse had called requesting verification of when the resident had last received an antibiotic medication at the nursing home. Interview on 2/26/20 at 4:50 p.m. with registered nurse (RN) D regarding resident 12's transfer to the emergency room revealed: *She had completed an Emergency Medical Transportation (EMT) form for the ambulance crew to take with the resident to the emergency room. -That form included areas to document the resident's name, current vital signs, the reason why the resident was sent to the emergency room, a place for the name of the person who had completed the form, and their contact number. *RN D stated she had not made a copy of the completed EMT form for the resident's chart. *She had printed an MD (medical doctor)/Nursing Communications report that was also sent with the resident to the emergency room. -That form pulled information from the resident's computer record and included her weight, vital signs, diagnoses, medication list, and allergies. -It did not include the resident's code status.	F 624	Education for all RN/LPN **by Administrator** on transfer discharge process will be completed by March 24th, 2020. All residents transferred to another facility will have the Point Click Care face sheet sent with them which includes resident advance directive status. Point Click Care transfer form will be sent with each resident along with current physican orders and Medication Administration record. DON or designee will audit weekly and report to QAPI monthly times 6 months. **Updated Policy was completed by 3/24/2020. 3/26/2020 D.A.**	3/24/2020

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F 624	Continued From page 9 *RN D said she had entered a comprehensive note in the resident's record that included details about the reason for the emergency department transfer and the type of records that had been sent with the resident to the emergency department. Interview on 2/26/20 at 5:15 p.m. with director of nursing (DON) B regarding the transfer of resident 12 to the emergency room earlier that day revealed: *It was her expectation the EMT form was thoroughly completed and copied for the ambulance driver to take to the emergency department. -The original, completed EMT form was to remain in the resident's record at the facility. *It was her expectation a copy of the current Physician's Order Summary was sent with the resident to the emergency department. -The Physician's Order Summary had included all active physician orders for a resident (including medications), but did not include information about the last time those medications had been administered. *It was her expectation a nursing progress note was written regarding the emergency room transfer that included family notification information, what medical records had been sent with the resident to the emergency room, and the reason for the emergency room transfer. *She stated the use of the MD/Nursing Communications form was not a part of their emergency room transfer process. *She confirmed a copy of the resident's advance directive was not sent with the resident to the emergency department. 2. Review of resident 21's closed medical record	F 624		

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F 624	Continued From page 10 revealed: *A nursing progress note dated 1/10/20 at 5:37 p.m. read: "Resident had another seizure and vitals are dropping. DON B aware and daughter aware as well. VS [vital signs] 98.2, 116-22, B/P [blood pressure] 77/55. Ambulance called and med list sent." -There was no EMT form found in that record. 3. Review of resident 38's closed medical record revealed: *Nursing progress notes indicated he had a decline in his oxygen saturation despite efforts to increase oxygen perfusion. -DON B, the resident's provider, and the guardian were notified. *A nursing progress note dated 1/11/20 at 6:03 p.m. read: "Contact information was given to EMS [emergency medical services] crew for Medicine Wheel Village, as well as for resident's guardian." -There was no EMT form found in that record. Interview on 2/28/20 at 11:00 a.m. with DON B regarding the process for resident transfers to the emergency department revealed: *There was no policy that outlined the process for facility to emergency room transfers. *She agreed a comprehensive and consistent process was needed to ensure the emergency department staff had the information they needed to effectively and efficiently treat the resident. Review of the revised December 2016 Advance Directive policy revealed: "20. The Nurse Supervisor will be required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of such directive	F 624		

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F 624	Continued From page 11 when transfer from the facility via ambulance or other means is made." Review of the undated Reducing Acute Care Transfers policy revealed: "4. Detailed information regarding acute care transfers will be reviewed at regular intervals and data will be reported to the QAPI (Quality Assurance Performance Improvement) Committee as part of the overall facility quality assurance and performance improvement plan."	F 624		
F 658 SS=E	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: Surveyor: 29162 Surveyor: 40053 Based on observation, interview, and record review, the provider failed to ensure: *Five of five sampled residents (9, 13, 22, 24, and 26) who were on fluid restrictions had daily fluid restriction amounts monitored and documented. *One of one sampled resident (3) who was on a fluid restriction had a documented physician's order in Point Click Care for it, and her treatment administration record and careplan had been updated to reflect the fluid restriction. Findings include: 1. Observation on 2/27/20 at 11:55 a.m. while in	F 658	Education for **all** Dietary staff and CNA/CMA and RN/LPN **by administrator** to be completed by 3/24/2020 for fluid restrictions. Education for **all** dietary staff on glass ounce sizes and daily fluid restriction amounts for all residents with Fluid restriction **by Administrator and dietary manager** to be completed by 3/24/2020. All residents with a Fluid restriction have been updated in Point Click Care and Point of Care for amounts consumed,TAR and Care plan. **Resident 3 has a physicans order and TAR/CP updated.** DON or designee will audit weekly for fluid restriction daily consumption,documentation and report to QAPI monthly times 6 months. **3/25/2020 D.A.**	3/24/2020

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F 658	Continued From page 12 the kitchen revealed: *Dietary staff had been preparing and serving the afternoon meal. *There had been a typed paper attached to a stainless steel fixture. -That heading read: *"Residents of Dialysis. Fluid Restriction of 240 ML [milliliter]/8 oz. [ounce] per meal." *Headings of Monday through Saturday were listed on that paper. -Resident's individual names were listed under the day headings. *Resident's 22 and 26 were listed under Monday, Wednesday, and Friday. *Resident's 3 and 13 were listed under Tuesday, Thursday, and Saturday. Interview on 2/27/20 at 4:56 p.m with dietary aide L and dietary cook M revealed: *The above paper hanging on the stainless steel fixture had been for fluid restrictions of residents on dialysis. -They stated all residents on dialysis were on some type of fluid restriction. *The dietary staff controlled what happened in the kitchen. -They monitored the fluid intake during meals. *Nursing would get the dietary staff confused on the fluid amounts for the day. -Nursing had been inconsistent with counting fluids. *They stated one nurse might give a resident something to drink. -Another nurse might have said no to the same resident request. *There was no consistency. Medical record review for residents 3, 13, 22, and 26 regarding fluid restrictions revealed:	F 658		

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	43A138	A. BUILDING _____ B. WING _____	C 02/28/2020

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F 658	Continued From page 13 *Physician's orders in Point Click Care (PCC) for residents 13 and 22 had been entered. -Residents 3 and 26 had not had physician entered orders for fluid restrictions. *Care plans revealed residents 13 and 22 had fluid restrictions documented. -Residents 3 and 26 had none documented. *Treatment administration records (TAR) revealed residents 13, 22, and 26 had fluid restrictions documented. -Resident 3 had none documented. 2. Review of resident 9's medical record revealed a 11/21/19 physician's order for, "Fluid intake 3,000 cc's [cubic centimeter] in a 24 hour period." Review of resident 9's revised 1/19/20 care plan revealed no mention of a physician ordered fluid restriction. Observation on 2/26/20 at 2:45 p.m. revealed resident 9 had been wheeling down the hall with a plastic water cup full of ice chips. She stated the kitchen staff had gotten it for her. Observation on 2/26/20 at 5:30 p.m. of the evening meal revealed resident 9 had one full glass of liquid at her place. Interview on 2/28/20 at 9:00 a.m. with cooks G and M regarding resident 9 revealed they: *Served her approximately four to five ounces of fluid three times a day at meals. *Used the same size glass everyone in the dining room used. *Thought that glass had been eight ounces and they just guessed at the amount to put in the glass. *Stated the:	F 658	Residents 9, 3, 22,24,26 fluid restriction have been updated in Point Click Care ,TAR , Care Plan and Point of Care for amounts consumed DON or designee will audit weekly for fluid restriction daily consumption,documentation and report to QAPI monthly times 6 months.	3/24/2020

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F 658	Continued From page 14 -Remainder of her fluid restriction was managed by the nursing staff. -Water cups used for the residents in their rooms had been twelve ounces. -Dietary manager had instructed them on the above. Interview on 2/28/20 9:40 a.m. with resident 9 revealed she: *Received three cans of pop per day from the nurse. *Received a twelve ounce water cup of ice chips in the afternoon and evening. 3. Review of resident 24's medical record revealed a 10/3/19 physician's order for "Fluid restrictions per her Dialysis Doctor to 1800 ml [milliliter] in 24 hours or 6-8 oz. with meals." Review of resident 24's 1/19/20 care plan made no mention of a physician's ordered fluid restriction. Interview on 2/27/20 at 3:25 p.m. with dietary manger J regarding resident 24's fluid restriction revealed: *Dietary served her four to six ounces of liquid at each meal. *They used the same size glass everyone in the dining room used. *She thought that glass had been eight ounces and just guessed at the amount to put in the glass. *She stated: -"We cut down on the liquid in soups." -"We served the liquid at meals and nursing has the rest." -"Sometimes nursing would come in and say they (resident) could not have something in particular	F 658		

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F 658	Continued From page 15 to eat or drink, and then another nurse would come back and say they could. So we did not always know." -We do the best we can and then they are responsible "out there". 4. Review of resident 26's medical record revealed diagnoses for: -End stage renal disease. -Renal dialysis. -Type 2 diabetes mellitus. Observation on 2/26/20 at 12:21 p.m. of resident 26's room revealed: *The door was open. *There was a clear drinking container with a blue lid on his bedside table. -That container was empty. Review of resident 26's medical record revealed: -No physician's order for fluid restrictions. -No careplan fluid restriction's documented. -Treatment assessment record (TAR) revealed a fluid restriction of 1800 ml in a 24 hour period. 5. Interview on 2/27/20 at 3:45 p.m. with registered nurse R revealed: *She used applesauce for medication instead of liquid. *Dietary served eight ounces of liquid at three meals a day. *The nurse and aides managed the remainder of the resident's fluid restriction. *She gave the resident's on fluid restriction 100 ccs of liquid mid-morning and mid-afternoon. *No twenty-four total fluid intake was done for any residents with a fluid restriction. Interview on 2/27/20 at 3:54 p.m. with	F 658		

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F 658	Continued From page 16 administrator A and director of nursing (DON) B concerning residents' fluid restrictions revealed: *DON B stated dietary gave fluids with meals, and the nurses gave fluids with medications. *Administrator A stated she and DON B had just discussed the need for a procedure to document a resident's fluid intake who had an order for fluid restrictions. -They did not have anything currently in place. *Administrator A stated there needed to be a form to keep track of fluids for residents which they did not currently have. Interview on 2/28/20 at 12:42 p.m. with licensed practical nurse N regarding residents on fluid restrictions revealed: *Dietary documented the fluids they gave to residents. -There had been no where in PCC or a form had not been developed for nursing to document what fluids they had been giving to residents. *She agreed resident 3 was on a fluid restriction due to her being on dialysis. *She stated resident 3 had been on a 1500 or 1800 cubic centimeter (cc) fluid restriction. -She was unable to find a physician's order, TAR, or careplan in PCC for resident 3 that had documented her fluid restriction. *She agreed there needed to be: -A physician's order. -Entry on the TAR. -Entry in the careplan. Interview on 2/28/20 at 12:54 p.m. with certified nursing assistant O concerning residents' fluid restrictions revealed the nurses would let her know if a resident was on a fluid restriction. Interview on 2/28/20 at 10:00 a.m. with DON B	F 658		

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F 658	Continued From page 17 confirmed the above findings. She stated they had not been completing a twenty-four hour fluid intake calculation for the residents who had a fluid restriction. Interview on 2/28/20 at 10:10 a.m. with administrator A revealed the provider did not have a policy for fluid restriction management.	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident	F 660	Education for Social Services designee and Interdisciplinary team **by Administrator** on Discharge Planning to be completed by 3/24/2020. Residents 3 ,13 and 22 have updated discharge planning noted in their care plan. DON or designee will review weekly **that discharge planning has been completed for all residents** and report to QAPI monthly times 6 months. **3/27/2020 D.A.**	3/24/2020

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F 660	Continued From page 18 representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the	F 660		

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F 660	Continued From page 19 evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on observation, interview, record review, and policy review, the provider failed to initiate discharge planning for three of five sampled residents (3, 13, and 22) who were planning on returning home or moving into the assisted living side of this facility. Findings include: 1. Review of resident 13's medical record revealed: *She had been admitted on 11/18/19 from a rehabilitation and care facility. *Her Brief Interview for Mental Status (BIMS) assessment score had been fifteen indicating no cognitive impairment. *Her diagnoses included: -Cerebral infarction. -End stage renal disease. -Renal dialysis. Observation and interview on 2/26/20 at 12:47 p.m. with resident 13 revealed: *She was sitting in her wheelchair in her room. *She was at her sewing machine and working on a quilt. *She stated she was there to get stronger. *She would like to leave the facility and go home once that had been accomplished. Record review of resident 13's undated careplan revealed no discharge planning had been	F 660		

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F 660	Continued From page 20 documented. 2. Review of resident 3's medical record revealed: *She had been admitted on 1/22/20 from the provider's assisted living facility. *Her BIMS assessment score had been fifteen indicating no cognitive impairment. *Her diagnoses included: -Type 2 diabetes mellitus. -End stage renal disease. -Renal dialysis. Observation and interview on 2/26/20 at 1:13 p.m. with resident 3 revealed: *She had been sitting on her bed with her bedside table in front of her. -She had been coloring in an adult coloring book. *She stated she had been moved to the long term care area when she had gotten an infection. -She did not have an infection anymore and wanted to move back to the assisted living side of the facility. Review of resident 3's 2/12/20 at 3:48 a.m. progress social services designee (SSD) I's note revealed: *"Communication with resident. -Late entry. -I [SSD I] did a one to one with her she likes being in the nursing home side. She did ask me if she would ever get to go back to the assisted living side. -I told her that was up to the MDS [Minimum Data Set] paperwork and her doctor." 3. Review of resident 22's medical record revealed:	F 660		

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F 660	Continued From page 21 *He had been admitted on 7/12/19. *His BIMS assessment score had been fifteen indicating no cognitive impairment. *His diagnoses included: -Right leg below the knee amputation. -Chronic kidney disease. -Renal dialysis. Observation and interview on 2/27/20 at 10:47 a.m. with resident 22 revealed: *He had been in his room sitting in his wheelchair. -He was pulled up to his desk playing with his cell phone and listening to music. *He had wanted to be discharged to the assisted living side of this facility. *He stated they had set goals for him to move to the assisted living side. -Once those goals had been met the facility changed them. 4. Record review of residents 3, 13, and 22's undated careplans indicated no discharge planning. Interview on 2/27/20 at 10:12 a.m. with SSD I concerning the above residents discharge planning revealed: *She had spoken to those residents about discharging but had not documented that on their careplans. -She had not documented those conversations. *She had not initiated discharge planning for anyone in the facility. *She stated, "I did not know I had to do discharge planning for everyone in the facility." Interview on 2/27/20 at 4:06 p.m. with administrator A and director of nursing B	F 660		

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F 660	Continued From page 22 concerning discharge planning revealed: *The expectation would have been elderly protection, the resident's guardian, or the resident would have had a discussion with SSD I concerning that. *Administrator A stated she would have expected the discharge planning with SSD I to have begun when residents entered the facility. -She stated, "SSD I knows that." Review of the provider's last modified 11/16/16 Social Services Designee job title revealed: "Provides range of clinical services to include assessment of individual and/or departmental needs, short term treatment, referral, crisis intervention and psycho-educational training." Review of the provider's revised December 2016 Care Plans, Comprehensive, Person-Centered policy revealed: *"A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. -8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframe's: f. Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire;..."	F 660		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails.	F 700		

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F 700	Continued From page 23 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: Surveyor: 29162 Based on observation, interview, record review, and policy review, the provider failed to ensure safety assessments were complete for five of five residents (5, 6, 9, 11, and 16) who had positioning devices on their beds. Findings include: 1. Observations and record review on 2/26/20 from 11:30 a.m. through 6:00 p.m. and on 2/27/20 from 9:30 a.m. through 5:30 p.m. revealed residents 5, 6, 9, and 11 had positioning bars on their beds. There had been no documentation of safety assessments for positioning bar use for any of those residents.	F 700	Education to maintenance and IDT team on bed and mattress safety assessments **by administrator** to be completed by 3/24/2020. **All residents have completed safety assessment on chart for posisitoning bar use.** Administrator or designee will review monthly all resident charts for safety assessments and preventative maintenance assessments and report to QAPI times 12 months. **Policy updated for safety assessments to be completed for IDT and Maintenance monthly preventative checks in TELS online preventative maintenance program.** **3/26/2020 D.A.**	3/24/2020

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F 700	Continued From page 24 Surveyor: 40788 2. Observations and record review on 2/26/20 between 12:28 p.m. and 1:33 p.m. and on 2/27/20 between 9:52 a.m. and 4:55 p.m. of resident 16 revealed: *He had bilateral positioning bars on his bed. *There were no safety assessments for positioning bar use in his record. Review of resident 16's revised 2/7/20 care plan revealed no goal or intervention related to the use of the bilateral positioning bars on his bed. 3. Interview on 2/27/20 at 1:20 p.m. with Minimum Data Set assessment coordinator P revealed: *There had not been safety assessments done regarding any of the positioning bars for the above five residents. *She had been unaware of a requirement for resident safety assessments with the use of positioning bars. Interview on 2/27/20 at 1:35 p.m. with director of nursing B confirmed the above. She had not known a safety assessment should have been done for the safe use of the positioning bars. Interview on 2/28/20 at 9:45 a.m. with administrator A confirmed the above findings regarding the use of positioning bars. Review of the provider's December 2007 Bed Safety policy revealed no mention of a safety assessment being done.	F 700	Residents 5, 6, 9, 11 and16 care plan revision to be completed by 3/24/2020 related to goals and intervention for bilateral positioning bars on bed and safety assessments by maintenance.	3/24/2020
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.	F 732	All RN/LPN will be educated on Posted Nurse Staff Posting **by administrator** by March 24, 2020. Nurse Staff posting is posted at 400 Nurses station and completed on a daily basis. DON or designee will audit weekly and report to QAPI times six months. **3/27/2020 D.A.**	3/24/2020

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F 732	Continued From page 25 §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (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(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(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 and visitors. §483.35(g)(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(g)(4) Facility data retention requirements. The 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: Surveyor: 40788 Based on observation, interview, review of posted	F 732		

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	43A138	A. BUILDING _____ B. WING _____	C 02/28/2020

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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F 732	Continued From page 26 direct care staffing information, and policy review, the provider failed to ensure the number of nursing personnel responsible for providing direct care to residents was available to visitors and residents. Findings include: 1. Observation on 2/26/20 at 4:00 p.m. of the direct care daily staff information revealed: *It was posted on a cabinet door near the residents' records. -That area was located between a secured hallway that separated the two nursing home living units. -There was a sign on each hallway door that read Authorized Staff. Interview on 2/27/20 at 2:40 p.m. with director of nursing B revealed: *She was responsible for ensuring that direct care staffing information form was completed, accurate, and posted daily. *She was unaware that information was expected to be posted in an area where visitors and residents could see it. Review of the revised July 2016 Posting Direct Care Daily Staff Numbers policy revealed: *Policy Interpretation and Implementation: -"1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (Registered Nurses, Licensed Practical Nurses, and Licensed Visiting Nurses) and the number of unlicensed nursing personnel (Certified Nurse Assistants) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format."	F 732		
F 909	Resident Bed	F 909		

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F 909 SS=E	Continued From page 27 CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, interview, record review, and policy review, the provider had not assessed the side rails on five of five sampled residents' beds (5, 6, 9, 11, and 16) initially or on a preventative maintenance (PM) program to ensure the rails were compatible to the bed frame, sturdy, and safe from possible resident entrapment. Findings include: 1. Observations and record review on 2/26/20 from 11:30 a.m. through 6:00 p.m. and on 2/27/20 from 9:30 a.m. through 5:30 p.m. revealed residents 5, 6, 9, and 11 had positioning bars on their beds. There had been no evidence of any type of equipment safety evaluations having been done. Surveyor: 40788 2. Observations and record review on 2/26/20 between 12:28 p.m. and 1:33 p.m. and on 2/27/20 between 9:52 a.m. and 4:55 p.m. of resident 16 revealed: *He had bilateral positioning bars on his bed. *There were no equipment safety evaluations in his record.	F 909	Education for Maintenance **by Administrator** to conduct regular inspection of all bed frames, mattresses and bed rails by March 24,2020 Residents 5,6, 9,11 and 16 have had inspections completed of bed frame, mattress and bed rail. Administrator or designee will audit that **TELS preventative maintenance program completed weekly** and report to QAPI monthly times 6 weeks. **3/26/2020 D.A.**	3/24/2020

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F 909	Continued From page 28 3. Interview on 2/27/20 at 2:00 p.m. with maintenance supervisor Q revealed the maintenance department had not: *Completed any type of equipment safety evaluations or assessments when postponing rails were attached to a bed. *Done routine preventative maintenance evaluations on the positioning rails on any of the above residents' beds. Interview on 2/27/20 at 1:20 p.m. with administrator A revealed no safety or equipment assessments had been done for any of the positioning rails used on residents' beds. Review of the provider's last revised December 2007 Bed Safety policy revealed: *"2. To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: a. Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; b. Review that gaps within the bed system are within the dimensions established by the FDA [Food and Drug Administration] (Note The review shall consider situations that could be caused by the resident's weight, movement, or bed position.); c. Ensure that when bed system components are worn and need to be replaced, components meet manufacturer specifications; d. Ensure that bed side rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from	F 909	Education to maintanence on equipment safety evaluations , preventative maintanenance evaluations **by Administrator** will be completed by March 24,2020. Administrator or designee will review weekly **that TELS preventative program completed** and report to QAPI monthly times six months. **3/26/2020 D.A.**	3/24/2020

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F 909	Continued From page 29 the headboard and footboard, etc.); and e. Identify additional safety measure for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., altered mental status, restlessness, etc.)."	F 909		

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E 000	Initial Comments Surveyor: 40788 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 from 2/26/20 through 2/28/20. Medicine Wheel Village was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deb Arbogast
TITLE: Nursing Facility Administrator
(X6) DATE: 3/26/2020

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

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	43A138	A. BUILDING 01 - MAIN B. WING _____	02/28/2020

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K 000	INITIAL COMMENTS Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted from 2/26/20 to 2/28/20. Medicine Wheel Village was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K222, K271, K291, K321, K324, K345, K346, K353, K354, K363, K712, K918, and K919 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=E	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	K 222		

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

TITLE
Nursing Facility Administrator

(X6) DATE
3/18/2020

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

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K 222	Continued From page 1 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 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 ARRANGEMENTS 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 ARRANGEMENTS 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.	K 222		

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation, interview, and testing, the provider failed to ensure magnetically locked egress doors at one of one north exit and one of two exits (outside door) in the spiritual room would release: *After fifteen seconds. *Upon initiation of the fire alarm. Findings include: 1. Observation on 2/27/20 at 11:45 a.m. revealed the north exterior exit door and outside exit door in the spiritual room were labeled as delayed egress locked doors. Testing of those doors by applying force in the direction of the path of egress revealed the audible signal would sound. But the required irreversible process of unlocking the doors did not initiate. Observation on 2/28/20 at 1:20 p.m. during the initiation of the fire drill revealed the same two doors listed above would not release from the magnetic hold open device. Interview at the time of the above observations with the maintenance supervisors confirmed those conditions. They stated the door service company had recently checked those doors as they had not been working correctly. They were not aware those doors were still not working correctly. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected two of three exits on the	K 222	Education to maintenance **by Administrator** on egress doors operation and testing to be completed by 3/24/2020. Convirgent has been notified and will schedule in facility work to fix these doors at north exit and ceremonial room. Administrator or designee will review monthly and report to QAPI times 6 months. **Maintenance will test egress doors daily to ensure they are in working order, reporting to Administrator weekly. Administrator or designee will audit weekly and report to QAPI monthly times 6 months. 3/25/2020 D.A.**	4/18/2020

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K 222	Continued From page 3 north end of the facility.	K 222		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to ensure there was a clear path of egress to the public way for six of seven outside exits (all but the main entrance) that were not cleared of snow. Findings include: 1. Observation on 2/27/20 from 9:00 a.m. through 12:30 p.m. revealed six outside exits, all but the main entrance, were not cleared of snow. Those exits had either three to four inches of snow or drifts of snow. Interview with the maintenance supervisors at the time of the observations confirmed those conditions. They stated there was another maintenance person who was responsible to clear the sidewalks and areas directly outside of the egress doors. But he apparently had not done his job, and now inches of ice and snow had built-up outside the exit doors. The deficiency had the potential to affect 100% of the facilities occupants.	K 271	Education to maintenance on snow removal for all exits will be completed by 3/24/2020. Administrator or designeee will review snow removal at each snow fall and report to QAPI times 12 months. **Education to maintenance provided by Administrator. 3/25/2020 D.A.**	3/24/2020
K 291	Emergency Lighting	K 291		

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K 291 SS=F	Continued From page 4 CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to inspect and test the emergency lighting for thirty seconds monthly and ninety minutes annually as required. Findings include: 1. Record review on 2/27/20 at 3:00 p.m. revealed there was no inspection report for testing of the emergency lighting for thirty seconds monthly and ninety minutes annually. Interview at the time of the record review with the maintenance supervisors confirmed that finding. They stated they had an on-line preventative maintenance program but had not ensured all the required preventive maintenance items had been completed. Failure to provide emergency lighting as required increases the risk of death or injury due to fire. The deficiency affected two of numerous requirements for emergency lighting that affected the occupants of the entire facility.	K 291	Education to maintenance for testing emergency lighting for thirty seconds monthly and ninety minutes annually by 3/24/2020. Administrator or designee will review monthly and report to QAPI times 12 months. **Education completed by Administrator to maintenance department with testing for emergency lighting to be completed by 3/24/2020 and maintenance reporting to Administrator monthly. 3/25/2020 D.A.**	3/24/2020
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour	K 321		

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K 321	Continued From page 5 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation, interview, and testing, the provider failed to ensure doors and/or door closers were maintained for three separate hazardous areas: *300 hall large clean supply room. *Housekeeping cart room. *Food pantry. Findings include: 1. Observation and testing on 2/27/20 from 9:00	K 321	Education maintenance on ensuring doors and or door closures were maintained to be completed by 3/24/2020. Aberdeen House of Glass contacted and will be in facility to correct door closers for doors at 300 hall large clean supply room , housekeeping cart room and food pantry room door. Administrator or designee will review monthly and report to QAPI times six months. **Education completed by Administrator to maintenance department , audit for door closure to be completed weekly by maintenance, reporting findings to Administrator weekly with monthly reports to QAPI times six months. 3/25/2020 D.A.**	4/18/2020

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K 321	Continued From page 6 a.m. to 12:30 p.m. revealed: *The 300 hall clean supply room's double, forty-five minute rated self-closing doors would not close and latch into the frame. *The large housekeeping cart room's forty minute rated self-closing door would not latch into the frame. The door would bounce off the lock and not latch. *The food pantry was approximately 100 square feet. The door was unrated and had no self-closer. Interview at the time of the observations and testing with the maintenance supervisors confirmed those findings. They stated they did not have a preventative maintenance checklist to monitor the operation of all doors in the facility. The deficiency affected two of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of two smoke compartments.	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K 324		

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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
K 324	Continued From page 7 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on record review and interview, the provider failed to conduct the required bi-annual inspection of the kitchen's fire suppression system for two of two range hoods. Findings include: 1. Record review on 2/27/20 at 3:00 p.m. revealed there were no kitchen hood fire suppression system records for the bi-annual inspections conducted in 2019. The kitchen hood fire-suppression system should have been inspected not less than every six months. Interview at the time of the record review with the maintenance supervisors revealed they were not aware they should have inspections of the fire suppression system. Nor did they know where the paperwork was located for the commercial inspections of the kitchen hoods. They stated they had an on-line preventative maintenance program but had not ensured all the required preventive maintenance items had been completed.	K 324	Education **by Administrator** to maintenance for kitchen hood fire suppression bi annual checks will be completed by 3/24/2020. Facility will contract this inspection for biannual checks **with completion on 3/24/2020**. Administrator or designee will review monthly and report to QAPI times 12 months. **3/25/2020 D.A.**	4/18/2020

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MEDICINE WHEEL VILLAGE	**24266 AIRPORT ROAD PO BOX 880 EAGLE BUTTE, SD 57625**

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K 324	Continued From page 8 This deficiency affected one of numerous kitchen hood fire suppression system requirements.	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on record review and interview, the provider failed to do the annual commercial inspection for the fire alarm system as required for calendar year 2019. Findings include: 1. Record review on 2/27/20 at 3:00 p.m. revealed there was no documentation an annual fire alarm inspection and testing had been performed for calendar year 2019. The last documented fire alarm inspection had been performed on 6/27/18. Interview with the maintenance supervisors at the tine of the document review revealed the fire alarm inspection from 2018 was the only record they could find. They stated they had an on-line preventative maintenance program but had not ensured all the required preventive maintenance items had been completed.	K 345	Education to maintenance **by Administrator** on annual fire alarm inspection and testing will be completed by 3/24/2020. Rapid Fire and Bancoe documentation records have been requested for 2019 **with request for 2020 inspection to be completed by 4/18/2020.** Administrator or designee will review **monthly and** report to QAPI times 12 months **3/25/2020 D.A.**	4/18/2020

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K 345	Continued From page 9 Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency had the potential to affect 100% of the building occupants.	K 345		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on document review and interview, the provider failed to have a written policy for when the required fire alarm system was out of service for more than four hours in a twenty-four hour period. Findings include: 1. Review of the maintenance records and inspection reports on 2/27/20 at 3:00 p.m. revealed there was no written policy stating if the fire alarm system was out of service for more than four hours in a twenty-four period then: *All staff would be notified of the situation. *The local fire department would be notified. *The Department of Health would be notified. *A fire watch would be initiated. Interview on 2/28/20 at 2:30 p.m. with the administrator revealed she was not aware if they	K 346	Education to maintenance and **all staff by Administrator** on MWV policy for **fire alarm system out of service for more than 4 hours** to be completed by 3/24/2020. Administrator or designee will review at time of Fire watch that policy is followed and report to QAPI times 12 months **3/25/2020 D.A.**	3/24/2020

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K 346	Continued From page 10 had a policy but was aware of the need for the policy. This deficiency affected one of numerous requirements for the fire alarm system.	K 346		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 20031 A. Based on record review and interview, the provider failed to conduct the required annual testing of the backflow preventer on the automatic sprinkler system. Findings include: 1. Review of the provider's sprinkler maintenance records on 2/27/20 at 3:00 p.m. revealed no documentation the required annual testing of the	K 353	Education to maintenance **by Administrator** on required annual sprinkler testing of the backflow preventer on the automatic sprinkler system to be completed by 3/24/2020. **Request for annual sprinkler testing of the backflow preventor to be completed by 4/18/2020.** Administrator or designee will review monthly and report to QAPI times 12 months. **3/25/2020 D.A.**	**4/18/2020**

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K 353	Continued From page 11 backflow preventer had been performed. Interview at the time of the record review with the maintenance supervisors revealed they were not aware a backflow inspection must be performed annually. They stated they had an on-line preventative maintenance program but had not ensured all the required preventive maintenance items had been completed. The deficiency affected a single component of the building's automatic fire sprinkler system required annual maintenance. B. Based on record review and interview, the provider failed to perform the five year internal obstruction inspection for the fire sprinkler system. Findings include: 1. Review of the provider's sprinkler maintenance records on 2/27/20 at 3:00 p.m. revealed no documentation the required five year internal obstruction inspection had ever been performed. Interview at the time of the record review with the maintenance supervisors revealed they were not aware the five year internal obstruction inspection was overdue. They stated they had an on-line preventative maintenance program but had not ensured all the required preventive maintenance items had been completed. The deficiency affected a single component of the building's automatic fire sprinkler system required maintenance.	K 353	Education to maintenance **by Administrator** on required five year internal obstruction inspection to be completed by 3/24/2020. **Request for five year internal inspection to be completed by 4/18/2020**. Administrator or designee will review monthly and report to QAPI times 6 months. **3/25/2020 D.A.**	4/18/2020
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101	K 354		

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K 354	Continued From page 12 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on record review and interview, the provider failed to have a written policy if the required automatic sprinkler system was out of service for more than ten hours in a twenty-four hour period. Findings include: 1. Review of the maintenance records and inspection reports on 2/27/20 at 3:00 p.m. revealed there was no written policy stating if the automatic sprinkler system was out of service for more than ten hours in a twenty-four hour period then: *All staff would be notified of the situation. *The local fire department would be notified. *The Department of Health would be notified. *A fire watch would be initiated. Interview on 2/28/20 at 2:30 p.m. with the administrator revealed they were following a letter from the automatic sprinkler inspection company for when the automatic sprinkler system was out	K 354	Education to maintenance **and all staff by Administrator for the automatic sprinkler system out of service for more than 10 hours** completed by 3/24/2020. Administrator or designee will review at each Fire watch that policy is enforced and report to QAPI **monthly times 12 months. 3/25/2020 D.A.**	3/24/2020

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K 354	Continued From page 13 of service. But they did not have a facility policy that stated as such. This deficiency affected one of numerous requirements for the automatic sprinkler system.	K 354		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or	K 363		

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K 363	Continued From page 14 frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation, interview, and testing, the provider failed to maintain one of two twenty minute rated self-closing corridors doors (employee break room) in the south smoke compartment. Findings include: 1. Observation on 2/27/20 from 9:00 a.m. to 12:30 p.m. revealed the door of the employee break room was crooked on the frame. Testing of that door revealed it would hit on the inside of the frame and could not close and latch. Interview at the time of the observation and testing with the maintenance supervisors confirmed that finding. They stated they were aware the door was not working properly but had not had time to repair the door. This deficiency affected all the occupants for the south smoke compartment.	K 363	Education to maintenance **by administrator** on fixing doors latches for twenty minute rated self-closing corridor doors by 3/24/2020. Door was fixed and is closing properly. Administrator or designee will review operation of twenty minute self closure doors monthly and report to QAPI times 6 months. **3/25/2020 D.A.**	3/24/2020
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at	K 712		

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K 712	Continued From page 15 least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on record review and interview, the provider failed to conduct a fire drill for 5 of 12 months (May, June, July, August, and September) of the calendar year 2019. Findings include: 1. Record review on 2/27/20 at 2:45 p.m. revealed no documentation a fire drill had been conducted in May, June, July, August, or September 2019. Interview at the time of the record review with the co-maintenance supervisors confirmed that finding. They stated they had assumed their duties in the spring. They were aware they must conduct monthly fire drills but had fallen behind in the summer. The deficiency had the potential to affect 100% of the building occupants.	K 712	Education to maintenance **by Administrator** on fire drills and requirement for monthly drills to **be completed once per month for 12 hour day shift and next month to be completed for 12 hour night** shift by 3/24/2020. Administrator or designee will review monthly and report to QAPI times 12 months. **3/25/2020 D.A.**	3/24/2020
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second	K 918		

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K 918	Continued From page 16 criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on record review and interview, the provider failed to ensure: *The generator set was inspected weekly for 2019 and January and February 2020. *The generator was run under load for 9 of 12 months (January, February, March, April, May, June, July, August, and September) for 2019.	K 918		

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K 918	Continued From page 17 *The generator was run under load at least thirty minutes monthly with an additional ten minute cool down for 2019 and January and February 2020. *At least 30% of the name plate value of the generator was documented every month for the past twelve months. Findings include: 1. Review on 2/27/20 at 3:00 p.m. of the generator records revealed: *There was no information the generator set had been inspected weekly with the appropriate information. *There was no information the generator had been run under load for January, February, March, April, May, June, July, August, and September 2019. *The generator had been run under load for ten to fifteen minutes without a cool down for October, November, and December 2019 and January and February 2020. *There was no documentation the generator run loads were at least thirty percent of the nameplate on the generator. Nor was there any information a load bank had been brought to the facility for a generator load test. Interview at the time of the record review with the maintenance supervisors revealed they were not aware: *A weekly inspection must be done of the generator set. *How to run a load test or that it should be for thirty minutes with a ten minute cool down. *A calculation for thirty percent of the nameplate on the generator must be documented to ensure it ran at thirty percent capacity or higher. The maintenance supervisors stated they had an	K 918	Education to maintenance **for requirements** for inspections for generator **weekly,** run a load test for 30 minutes with 10 minute cool down by 3/24/2020 **completed by Administrator.** Administrator or designee will **audit weekly** and **report monthly** to QAPI times 6 months. **3/25/2020 D.A.**	3/24/2020

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K 918	Continued From page 18 on-line preventative maintenance program but had not ensured all the required preventive maintenance items had been completed. The deficiency had the potential to affect 100% of the building occupants.	K 918		
K 919 SS=F	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on record review and and interview, the provider failed to replace the generator battery as required (battery installed in May 2016). Findings include: 1. Review on 2/27/20 at 2:45 p.m. of the annual maintenance report from a commercial inspector revealed no information a new battery had been installed for the generator. The last survey report dated 2/5/19 revealed the battery was installed in May 2016. That made it approximately forty-four months old. Per the National Fire Protection Association generator batteries are recommended to be replaced every twenty-four to thirty months. Interview at the time of the record review with the maintenance supervisors confirmed that finding.	K 919	Education to maintenance on the battery life for generator batteries and time frame for replacement completed **by Administrator** to be completed by 3/24/2020. **TELS preventative maintenance update in preventative maintenance audits added for generator batteries and time frame for replacement. 3 E** contracted to assist in replacement of this battery to meet federal requirements. Administrator will review that this is replaced and report to QAPI monthly times 6 months. **3/25/2020 D.A**	4/18/2020

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K 919	Continued From page 19 They stated they had an on-line preventative maintenance program but had not ensured all the required preventive maintenance items had been completed. The deficiency affected one of numerous requirements for generator maintenance.	K 919		

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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	Compliance/Noncompliance Statement Surveyor: 40788 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/26/20 through 2/28/20. Medicine Wheel Village was found not in compliance with the following requirements: S167, S169, S173, S195, S206, S210, and S236.	S 000		
S 167	44:73:02:18(3-4) Occupant Protection The facility shall take at least the following precautions: (3) Provide a call system for each resident bed and in all toilet rooms and bathing facilities routinely used by residents. The call system shall be capable of being easily activated by the resident and must register at a staff station serving the unit. A wireless call system may be used; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 20031 Based on observation, interview, and testing, the provider failed to ensure all cords on the bathing room call systems for one of four bathing rooms and three of four public restrooms in the 200 and 400 halls were available for immediate use. Findings include: 1. Observation and testing on 2/28/20 from 9:00 a.m. to 12:30 p.m. revealed the call cords in the 400 hall bathing room and three public bathrooms were either wrapped around the base of the wall	S 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deb Arbogast — TITLE: Nursing Facility Administrator — (X6) DATE: 3/19/2020

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	68814	A. BUILDING: _____ B. WING _____	02/28/2020

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S 167	Continued From page 1 unit or too far off the floor (twelve to eighteen inches) to be reached in a prone position. Interview at the time of the above observations with the co-maintenance supervisors H and Q confirmed the above finding. They stated they were aware some of the call cords were either wrapped or too short. They stated it had been given as technical assistance on the last survey on 2/5/19. They had not corrected the problem.	S 167	Education **by Administrator** for Maintenance on call lite (twelve to eighteen inches) to be reached in prone position will be completed by 3/24/2020. Call lite cords will be monitored for Length and wrapped around the base of the call lite unit with 15 randomn room checks **weekly by Administrator or designee** and report to QAPI monthly times six months. **3/25/2020 D.A.**	3/24/2020
S 169	44:73:02:18(5-7) Occupant Protection The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 20031 Based on observation, interview, and testing, the provider failed to ensure one of three common use areas (sunroom) was locked or had an alarmed exit door. Findings include:	S 169		

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S 169	Continued From page 2 1. Observation and testing on 2/28/20 at 9:30 a.m. revealed the outside exit door in the sunroom had no alarm and was unlocked. Interview with co-maintenance supervisors H and Q at the time of the observation confirmed that finding. They stated the outside exit door to the above rooms was to be kept locked.	S 169	Education **by Administrator** for Maintenance and **all staff** that the sunroom door (common use area) is to be locked at **all** times by March 24,2020, **The Administrator or designee will audit daily times 4 weeks , weekly times 5 months and report to QAPI times 12 months. 3/25/2020 D.A.**	3/24/2020
S 173	44:73:02:18(8-10) Occupant Protection The facility shall take at least the following precautions: (8) Any light fixture located over a resident bed, in any bathing or treatment area, in a clean supply storage room, in any laundry clean linen storage area, or in any medication set-up area shall be equipped with a lens cover or a shatterproof lamp; (9) Any clothes dryer shall have a galvanized metal vent pipe for exhaust; and (10) The storage and transfilling of oxygen cylinders or containers shall meet the requirements of the NFPA 99 Standard for Health Care Occupancies, 2012 Edition. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to ensure 8 of 12 fluorescent light bulbs in the large 300 wing storage room were shielded to prevent breakage. Findings include: 1. Observation on 2/28/20 at 9:30 a.m. revealed	S 173		

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S 173	Continued From page 3 all of the fluorescent light bulbs in the large storage room on the 300 wing were not shielded. The plastic bulb covers with end caps were missing from eight of the fluorescent bulbs. Interview at the time of the observation with co-maintenance supervisors H and Q revealed they were not aware those bulbs must be covered or shatterproof.	S 173	Education to maintenance **by administrator** that all of the fluorescent light bulbs must be shielded by March 24,2020. Will Clark Electric has been notified and will be in facility to fix the fluorescent light bulbs in the 300 supply room . Administrator or designee will review weekly and report to QAPI monthly times six months. **3/26/2020 D.A.**	4/18/2020
S 195	44:73:03:02 General Fire Safety Each facility covered under this article shall be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The fire alarm system shall be sounded each month. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 20031 Based on record review and interview, the provider failed to sound the fire alarm for 7 of 12 months (May, June, July, August, September, November, and December) of the calendar year 2019. Findings include: 1. Record review on 2/27/20 at 2:45 p.m. revealed no documentation a fire drill had been conducted in May, June, July, August, or September 2019. A silent drill was used for the fire drills in November and December 2019. Interview at the time of the record review with co-maintenance supervisors H and Q confirmed	S 195	Education for Maintenance **by Administrator on** sounding the fire alarm monthly ,when a silent drill is conducted and monthly documentation of fire drills by 3/24/2020. The Administrator or designee will **audit Documentation for sounding of the fire alarm monthly/silent drill conducted monthly and report to QAPI times 12 months. 3/26/2020 D.A.**	3/24/2020

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S 195	Continued From page 4 that finding. They stated they had assumed their duties in the spring and were not aware of the fire drill requirement. They were also not aware the fire alarm must be sounded monthly if they conducted an overnight fire drill when the alarm was silenced.	S 195		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (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; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on	S 206	Education to DON , Human Resources and Department Heads **by Administrator** on ongoing education requirements to be completed annually by 3/24/2020. Administrator or designee will review **Ongoing education program training for all employees including employees D , E, F, G and H who have contact with residents with new Relias online educational training programs.** Human Resources to audit **all current and new** employee **training completion** monthly and report to QAPI times 12 months. **3/25/2020** **D.A.**	**4/18/2020**

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S 206	Continued From page 5 facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40788 Based on record review and interview, the provider failed to ensure four of four sampled new employees (D, F, G, and H) had attended a formal orientation program and one of one sampled existing employee (E) had attended annual training that covered the following required subjects: fire prevention/response, emergency procedures/preparedness, infection control and prevention, accident prevention/safety procedures, proper use of restraints, resident rights, confidentiality of resident information, incidents/disease reporting, care of residents with unique needs, dining assistance, nutritional risks, hydration, and abuse, neglect, misappropriation, and mistreatment. Findings include: 1. Review of employee inservice training records for the above required subjects revealed: *Employee D had been hired on 12/10/19. -She had no record of orientation training. *Employee E had been hired on 5/1/15. -She had no record of required annual training. *Employee F had been hired on 6/6/19. -She had no record of orientation training. *Employee G had been hired on 8/8/19. -She had no record of orientation training. *Employee H had been hired on 1/23/19. -He had no record of required annual training. Interview on 2/27/20 at 2:00 p.m. with licensed practical nurse/infection preventionist/employee health/staff development person C revealed there was no orientation or annual training documentation.	S 206	Education to DON , Human Resources and Department Heads **by Administrator** on ongoing education requirements to be completed annually by 3/24/2020. Administrator or designee will review **Ongoing education program training for all employees including employees D , E, F, G and H who have contact with residents with new Relias online educational training programs.** Human Resources to audit **all current and new** employee **training completion** monthly and report to QAPI times 12 months. **3/25/2020 D.A.** Education to DON , Human Resources and Department Heads **by Administrator** on ongoing education requirements to be completed annually by 3/24/2020. Administrator or designee will review **Ongoing education program training for all employees including employees D , E, F, G and H who have contact with residents with new Relias online educational training programs.** Human Resources to audit all current and new employee **training completion** monthly and report to QAPI times 12 months. **3/25/2020 D.A.**	4/18/2020 4/18/2020

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S 206	Continued From page 6 Interview on 2/28/20 at 9:15 a.m. with administrator A confirmed there was no orientation or annual training documentation. A policy for new employee orientation training and annual employee training was requested on 2/28/20 at 9:00 a.m. from administrator A. She confirmed the facility did not have that policy.	S 206		
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40788 Based on interview, employee health record review, and policy review, the provider failed to ensure: *Two of five sampled employees (F and G) were	S 210		

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S 210	Continued From page 7 evaluated by a licensed health professional within fourteen days of being hired. *Four of five sampled employees (D, F, G, and H) had a health evaluation within fourteen days of being hired that addressed freedom from communicable disease. Findings include: 1. Review of the following employees' health records revealed: *Employee F had been hired on 6/6/19. -She was not assessed by a licensed health professional. *Employee G had been hired on 8/8/19. -She was not assessed by a licensed health professional. 2. Review of the following employees' health records revealed they had not been evaluated for freedom from communicable disease: *Employee D had been hired on 12/10/19; her health evaluation was dated 2/10/20. *Employee F had been hired on 6/6/19; her health evaluation was unsigned and undated. *Employee G had been hired on 8/8/19; her health evaluation was unsigned and undated. *Employee H had been hired on 1/23/19; his health evaluation was dated 1/5/19. 3. Interview on 2/27/20 at 2:00 p.m. with licensed practical nurse/infection preventionist/employee health/staff development person C revealed: *She confirmed it was her responsibility to ensure health evaluations were completed for new employees in a timely manner. *She was unaware employee F and G's health evaluations had not been signed. *She was unsure why not all of the health evaluations had been completed within fourteen days of an employee's hire date.	S 210	Education to Employee Health LPN **by Administrator** that all employees must have a health evaluation within 14 days of hire will be completed by 3/24/2020. **Employees D ,F ,G ,H and all other current employees will have updated Health evaualuation completed by 4/18/2020.** Human Resources or designee will review **all current and new** employee files monthly and report to QAPI monthly times 12 months. **3/25/2020D.A.**	**4/18/2020**

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S 210	Continued From page 8 *She was unaware all personnel were to have been evaluated by the licensed health professional for freedom from reportable communicable disease. Review of the revised January 2012 Employee Health Program policy revealed: *Policy Statement: -"Our facility's employee health program strives to promote the health, safety and well-being of our personnel and prevent the spread of communicable diseases among staff and residents." *Policy Interpretation and Implementation: -"3. Pre-employment examinations shall also be used to screen employees for signs, symptoms, and/or risk factors for communicable diseases."	S 210		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the	S 236	Education to Employee Health LPN by **Administrator** that all employees must have tuberculin screening evaluation within 14 days of hire will be completed by 3/24/2020. **Employee D ,F , G and H employee files updated with copy of TB testing.** Human Resources or designee will review monthly that **all new employees have tb screening within 14 days of hire and report to QAPI monthly times 12 months. 3/25/2020 D.A.**	3/24/2020

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S 236	Continued From page 9 last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40788 Based on interview, employee health record review, and policy review, the provider failed to ensure four of five sampled employees (D, F, G, and H) had been screened for tuberculosis (TB) within fourteen days of employment. Findings include: 1. Review of the following employees' health records revealed they had not been screened for TB within fourteen days of their employment: *Employee D was hired on 12/10/19. -Her first TB skin test was dated 10/19/15 and her second step skin test was dated 10/26/15. *Employee F was hired on 6/6/19. -She had no TB skin test documentation. *Employee G was hired on 8/8/19. -She had documentation from an outside provider that her TB skin test was completed on 10/20/20. *Employee H was hired on 1/23/19. -His first TB skin test was dated 1/22/19 and his second step skin test was dated 1/5/19. Interview on 2/27/20 at 2:00 p.m. with licensed practical nurse/infection preventionist/employee health/staff development person C revealed: *She agreed employee D should have had a more current TB skin test on file.	S 236		

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S 236	Continued From page 10 *She was aware employee F had no TB skin test on record. *She had thought the dates of employee G and H's TB skin tests were not accurate. -She had not investigated further either of these employees' TB skin tests. Review of the provider's revised July 2010 Employee Screening for Tuberculosis policy revealed: *New Employee Screening: "-1. Each newly hired employee will be screened for TB [tuberculosis] infection and disease after an employment offer has been made but prior to the employee's duty assignment. 2. The Employee Health Coordinator (or designee) will accept documented verification of two-step TST [tuberculin skin test] or BAMT [blood assay for mycobacterium tuberculosis] results within the preceding 12 months."	S 236		
S 000	Compliance/Noncompliance Statement Surveyor: 40053 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/26/20 through 2/28/20. Medicine Wheel Village was found not in compliance with the following requirement: S060.	S 000		
S 060	44:74:02:15(1-2) Nurse Aide Curriculum The curriculum of the nurse aide training program shall address the medical, psychosocial, physical, and environmental needs of the residents served by the nursing facility. Each unit of instruction shall include behaviorally stated objectives with	S 060		

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S 060	Continued From page 11 measurable performance criteria. The nurse aide training program shall consist of at least 75 hours of classroom and clinical instruction, including the following: (1) Sixteen hours of training in the following areas before the nurse aide has any direct contact with a resident; (a) Communication and interpersonal skills; (b) Infection control; (c) Safety/emergency procedures, including the Heimlich maneuver; (d) Promoting residents' independence; (e) Respecting residents' rights; and (f) Abuse, neglect, and misappropriation of resident property; (2) Sixteen hours of supervised practical training, with enough instructors to ensure that nursing care is provided with effective assistance and supervision. The ratio may not be less than one instructor for each eight students in the clinical setting; and This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40053 Based on interview and record review, the provider failed to ensure abuse, neglect, and misappropriation of resident property training had been completed before the nurse aide had any direct contact with a resident. Findings include: 1. Review of the nurse aide training program revealed there had not been training related to a required curriculum of abuse, neglect, and misappropriation of resident property. Review of the facilities training summary report for 2/1/18 through 2/3/20 revealed between	S 060	**Administrator** provided education on complete documentation for training summary report with DON and Staff Development RN will be completed by 3/24/2020. The Human Resources or designee will review **Nurse Aide training** records monthly and report to QAPI times six months. **3/25/2020 D.A.**	3/24/2020

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MEDICINE WHEEL VILLAGE	24266 AIRPORT ROAD PO BOX 880 EAGLE BUTTE, SD 57625

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S 060	Continued From page 12 2/14/19 and 10/2/19 ten candidates had completed nurse aide training. Interview on 2/28/20 at 1:06 p.m. with director of nursing A revealed: *She was also the Nurse Aide Training program coordinator. *She had been unaware that abuse, neglect, and misappropriation of resident property had not been completed as part of nurse aide training. *She agreed it needed to be completed as part of the nurse aide training. *She had been unable to produce documentation of completion of that required training to nurse aides before the exit conference on 2/28/20 at 3:30 p.m.	S 060	**Administrator provided education to current Nursing employees for abuse , neglect, misappropriation of resident property. Human resources or designee will audit monthly that all nursing assistant employees complete abuse , neglect, and misappropriation of resident property in their WE Care online nurse aide training program monthly and report to QAPI times 12 months.** **3/25/2020 D.A.**	**4/18/2020**