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

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 _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICINE WHEEL VILLAGE	24266 AIRPORT ROAD 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: 41895 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 4/4/22 through 4/6/22. Medicine Wheel Village was found not in compliance with the following requirements: F578 and F812. Medicine Wheel Village's vaccination program was reviewed for compliance with the Centers for Medicare and Medicaid (CMS) Quality, Safety and Oversight (QSO) memorandum QSO-22-09-ALL, dated January 14, 2022, from 4/4/22 through 4/6/22. Medicine Wheel Village was found in compliance.	F 000		
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.	F 578		

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

TITLE
Licensed Nursing Facility Administrator

(X6) DATE
4/28/2022

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.

APR 29 2022
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F 578	Continued From page 1	F 578		

(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an 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: 41895
Based on record review, interview, and policy review, the provider failed to ensure the code status for four of sixteen sampled residents (5, 8, 15, and 17) documented in three areas of the medical record had been the same in all three areas.

1. Review of resident 5's medical record revealed the:
*Paper medical record had been a form titled "Acknowledgement of Receipt Advance Directives/Medical Treatment Decisions."
-This form indicated he chose to have cardiopulmonary resuscitation (CPR).
-It had been signed by his guardian on 3/17/22.
*Electronic medical record indicated he chose to

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F 578	Continued From page 2 not have CPR. *Care plan indicated he had not wanted CPR. 2. Review of resident 8's medical record revealed the: *Paper medical record had been a form titled "Acknowledgement of Receipt Advance Directives/Medical Treatment Decisions." -This form indicated he chose not to be resuscitated. -It had been signed by him with two witnesses on 3/15/22 and the physician on 3/17/22. *Electronic medical record indicated he chose to have CPR. *Care plan indicated he wanted CPR. Surveyor: 45095 3. Review of resident 15's medical record revealed the: *Paper medical record had been a form titled "Acknowledgement of Receipt Advance Directives/Medical Treatment Decisions." -This form indicated he chose to have CPR. -His legal representative gave permission over the phone on 3/17/22. -It had been signed by him with two witnesses and the physician on 3/17/22. *Electronic medical record indicated he chose not to have CPR. *Care plan indicated he had not wanted CPR. 4. Review of resident 17's medical record revealed the: *Paper medical record had been a form titled "Acknowledgement of Receipt Advance Directives/Medical Treatment Decisions." -This form indicated he chose not to be resuscitated. -His legal representative gave permission over	F 578		

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F 578	Continued From page 3 the phone on 3/15/22. -It had been signed by him with two witnesses on 3/15/22 and the physician on 3/17/22. *Electronic medical record indicated he chose not to be resuscitated. *Care plan indicated he wanted CPR. Interview on 4/5/22 at 5:49 p.m. with licensed practical nurse (LPN) G about how she would find a resident's code status revealed she: *Would look at either the paper chart or the electronic medical record. *Had expected both the paper chart and the electronic medical record to be the same. Interview on 4/5/22 at 5:55 p.m. with social services director (SSD) D regarding the residents code status revealed: *A new form for code status had been initiated and code status for all residents had been reviewed and updated using the new form. *She agreed that the paper chart and the care plan should match signed code status form in the paper chart. *She had not realized all areas of residents medical record did not get updated. Interview on 4/5/22 at 6:00 p.m. with administrator A revealed: *She expected nurses to look at the electronic medical record for a resident's code status. *When the new code status form had been signed by the physician it should have been treated like a physician order and: -Entered into the electronic medical record -Updated on the care plan. Surveyor: 43844 Review of Provider's March 2022 advance	F 578	100% of Medicine Wheel Village code status forms, physican orders and care plans were updated on 4/5/2022 to all have the same code status in all areas (electronic record, paper form, physican order and care plans) . The MDS RN Coordinator will audit all resident charts to assure that the code status matches weekly times 8 weeks and monthly times 12 months. Audit findings will be reported to QAPI . 4/28/2022 DA	5/11/2022

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F 578	Continued From page 4 directive policy revealed: *"7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record." *"10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive." *"19. Changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new documents if changes are extensive. The Care Plan team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan."	F 578		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		

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F 812	Continued From page 5 Surveyor: 41895 Based on observation, interview, and policy review, the provider failed to ensure dietary staff had: *Appropriately tested the sanitizer levels in the dishwasher and in the three-compartment sink. *Ensured expired food had been removed from the refrigerator. *Ensured food stored in the refrigerator had been appropriately labeled and dated. Findings include: 1. Interview on 4/6/22 at 1:45 p.m. with dietary aide (DA) F regarding testing the sanitizer in the dishwasher revealed: *He checked the levels of the cleaning products and sanitizer for the dishwasher daily to ensure they were not running low. *There was a warning light on the dishwasher that would light up when it was low on soap or sanitizer. *He did not check the sanitizer to see if it was in an acceptable range to ensure the dishes were sanitized. *He stated they used to have some test strips to test the sanitizer but they had run out about a week ago. *There had not been a log used to record the sanitizer levels. Interview and observation on 4/6/22 at 1:46 p.m. with cook E regarding testing the sanitizer revealed: *She had not ever seen test strips for the three compartment sink so she did not test to see if it was in an acceptable range. *Agreed there had been an instruction sheet on the wall above the three compartment sink on how to test the sanitizer.	F 812		

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F 812	Continued From page 6 *She had been in the kitchen the day the dishwasher was installed and remembered being trained to use the test strips to see if the sanitizer was in an acceptable range. -The dishwasher had been installed about a year ago. -The person who installed the dishwasher had left testing strips, and they were to last about one year. *She thought they had run out of the test strips about one week ago. Interview on 4/6/22 at 1:47 p.m. with dietary manager (DM) C regarding testing the sanitizer revealed she: *Was not aware the sanitizer levels of the dishwasher and the three-compartment sink needed to be tested. *Did not know there had been no test strips available to the staff. *Agreed they did not have a log for documenting the sanitizer levels for the dishwasher or the three-compartment sink. On 4/6/22 at 2:00 p.m. surveyor had requested a policy for testing the sanitizer levels for the dishwasher and the three compartment sink. *Received a policy dated 4/6/22. *DM C had stated they did not have a policy so they had written one after it had been requested. Review of the Ecolab Oasis 146 Multi-Quat Sanitizer instructions that had been posted above the three compartment sink revealed it: *Gave instructions on how to test the levels and an acceptable range of 150 - 400 part per million. *Did not state how often to check the levels. *Did not give instructions on what to do if the level was not in acceptable range.	F 812	Medicine Wheel Village Dietary manager educated Dietary employees on the policy for testing the sanitizer for the dishwasher and three compartment sink on 4/6/2022. Daily logs have been completed for testing with the chem strips according to manufacturer guidelines Weekly Audits for completion of testing with the chem strips for the dishwasher and three compartment sink to be completed by the Dietary Manager times 8 weeks and monthly times 12 months. Dietary Manger will report Audit findings to QAPI monthly. 4/28/2022 DA	5/11/2022

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F 812	Continued From page 7 2. Observation on 4/4/22 at 12:20 p.m. in the kitchen of the three door refrigerator revealed: *One carton of lactose-free one percent milk with an expiration date of 3/11/22. *A small plastic container with a piece of fresh pineapple, it had a use by date of 3/29/22. *A small plastic bag containing a fresh piece of white onion, it was not dated. *A re-usable plastic container of green olives in a liquid, it was not dated. *A re-usable plastic container with food that appeared to be breaded chicken strips, it was not dated. *A large open bag of what appeared to be bits of cooked meat, such as bacon, it: -Did not have a date or label on it. -It was open and not sealed. Interview on 4/4/22 at 12:45 p.m. with the cook E revealed: *It was every one in the dietary departments responsibility to remove food from the kitchen when it was expired. *She had not noticed the above items were expired or not label appropriately. *She was going clean out the refrigerator. Observation and interview on 4/6/22 at 10:00 a.m. in the kitchen of the three door refrigerator with DM C revealed: *She had expected the dietary staff to dispose of food that was expired. *Residents were not to be served food that was expired. Interview on 4/6/22 at 1:15 p.m. with administrator A regarding the above observations and interviews revealed:	F 812	Dietary Manager reeducated all dietary employees on dating, storage and disposal of expired foods on 4/6/2022. Education to all Medicine Wheel Village employees on 5/4/2022 to be completed by Administrator on dating, storage and disposal of expired foods. Dietary Manager and or Dietary Cooks will audit dating, storage and disposal of expired foods and dietary manager will report audit finding to QAPI monthly times 12 months. 4/28/2022 DA	5/11/2022

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F 812	Continued From page 8 *She had expected dietary staff to dispose of expired food and not to serve it to the residents. *There had not been residents with signs or symptoms of gastrointestinal upset. Review of the providers 2014 Refrigerators and Freezers policy revealed: *"7. All food shall be appropriately dated to ensure proper rotation by expiration dates. "Received" dates (dates of delivery) will be marked on cases and individual items removed from cases for storage. "Use by" dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and "use by" dates indicated once food is opened. *8. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes."	F 812		

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E 000	Initial Comments Surveyor: 41895 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 4/4/22 through 4/6/22. Medicine Wheel Village was found not in compliance with the following requirement(s): E001.	E 000		
E 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and	E 001		

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

TITLE
Licensed Nursing Facility Administrator

(X6) DATE
4/28/2022

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E 001	Continued From page 1 local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on interview and record review, the provider failed to establish a comprehensive emergency preparedness (EP) program that included policies, procedures, communication plan, and contact information. Findings include: 1. Interview on 4/6/22 at 11:19 a.m. and at 1:20 p.m. with Administrator A and review of the provider's EP program documentation: *She had received a template for an EP program from a consultant. *She had not individualized this template for the facility. *They did not have a complete EP program. *They had not: -Addressed patient/client population, including, but not limited to persons at risk, type of services the facility had the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession	E 001	The Emergency Preparedness Program manual has been completed and education to all Medicine Wheel Village employees to be completed on 5/3/2022 on Medicine Wheel Village Emergency Preparedness procedures by Medicine Wheel Village Administrator. Monthly audit drill on emergency preparedness will be completed for staff knowledge and reported to QAPI monthly times 12 months by the Medicine Wheel Village Administrator. 4/28/2022 DA	5/3/2022

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E 001	Continued From page 2 plans. -Developed a system to track the location of on-duty staff in the facility during an emergency. -Addressed policies and procedures for: --Sheltering in place for residents, staff, and volunteers who remained in the facility. --Medical documentation that preserves patient information, protects confidentiality of patient information and secures and maintains availability of records. -Developed a communication plan that had included: --Names and contact information for resident physicians and volunteers. --Contact information for the state licensing and certification agency, and the office of the state long-term care ombudsman. --A method to provide information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee. *She had been aware of the requirements for a complete emergency preparedness program and had not included all the requirements.	E 001		

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 4/11/22. 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 K321, K324, K354, K355, K522, K712, and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 321 SS=D	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 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 Separation N/A — Automatic Sprinkler	K 321		

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

TITLE
Licensed Nursing Facility Administrator

(X6) DATE
4/28/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A138	A. BUILDING **01 - MAIN** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICINE WHEEL VILLAGE	**24266 AIRPORT ROAD 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
K 321	Continued From page 1 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: 18087 Based on observation and interview, the provider failed to ensure doors and/or door closers were maintained for two separate hazardous areas: *Maintenance shop. *Food pantry (labeled as Housekeeping). Findings include: 1. Observation on 4/11/20 from 9:45 a.m. to 10:00 a.m. revealed: *The maintenance shop door was held open by over-extending the door closer's mechanical limits. *The food pantry was approximately 100 square feet and was considered a hazardous storage room. The corridor door was held open with a box. Interview at the time of the observations and testing with the maintenance supervisor confirmed those findings. He stated the doors were held open to move supplies in and out of the rooms. The deficiency affected two of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants	K 321	All Medicine Wheel Village employees will be reeducated on not over extending the door closer mechanical limits at all staff inservice on 5/3/2022. The maintenance supervisor will audit that doors are not held open weekly times 8 weeks and monthly times 6 months. The maintenance supervisor will report to QAPI times 12 months. 4/28/2022 DA	5/3/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A138	A. BUILDING **01 - MAIN** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICINE WHEEL VILLAGE	**24266 AIRPORT ROAD 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
K 321	Continued From page 2 of the smoke compartment.	K 321		
K 522 SS=D	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview the provider failed to maintain combustion (fresh) air in one randomly observed area (laundry). Findings include: 1. Observation of the two commercial natural gas-fired dryers in the laundry room on 4/11/22 at 9:30 a.m. revealed the propane-fueled dryers had combustion (fresh) air ductwork. The dryers were running but the fresh air dampers were closed. The dampers were manually closed and would not automatically open with the operation of the dryers. Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated the laundry personnel got cold when outside temperatures were low and the dampers were open.	K 522	All Medicine Wheel Village employees will be educated on not closing the fresh air dampers for the gas-fired dryers by the maintenance supervisor on 5/3/2022. The maintenance supervisor will audit that the fresh air dampers are open weekly times 8 weeks and monthly times 12 months and report monthly to QAPI 4/28/2022 DA	5/3/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A138	A. BUILDING **01 - MAIN** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICINE WHEEL VILLAGE	**24266 AIRPORT ROAD** **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
K 522	Continued From page 3 The deficiency affected one of several requirements for fuel fired devices.	K 522		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 43A138	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN** B. WING	DATE SURVEY COMPLETE: **4/11/2022**
NAME OF PROVIDER OR SUPPLIER **MEDICINE WHEEL VILLAGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **24266 AIRPORT ROAD EAGLE BUTTE, SD**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 324	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 * 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: 18087 Based on record review and interview, the provider failed to conduct the required bi-annual inspection of the kitchen range hood ductwork for grease buildup. Findings include: 1. Record review on 4/11/22 at 10:30 a.m. revealed there were no records of the kitchen range hood being inspected for grease buildup (and cleaned as needed). Interview at the time of the record review with the maintenance supervisor revealed they were not aware they should have inspections of the kitchen range hood exhaust ventilation ductwork/system. He stated there was an on-line preventative maintenance program but had not ensured all the required preventive maintenance items had been completed. This deficiency affected one of numerous kitchen hood fire suppression system requirements.
K 354	Sprinkler System - Out of Service CFR(s): NFPA 101 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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	43A138	A. BUILDING: **01 - MAIN** B. WING	**4/11/2022**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 354	Continued From Page 1 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: 18087 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 4/11/22 at 10:45 a.m. revealed the dry sprinkler system had been out of service beginning January 15, 2022 through February, March, and April 11, 2022 and fire watches were being performed. Interview on 4/11/22 at 11:00 a.m. with the administrator revealed they were following the proper procedure for fire watch protocol. The intent of the fire watch was for short-term incidents and not a long-term solution. This deficiency affected one of numerous requirements for the automatic sprinkler system.
K 355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview the provider failed to ensure fire extinguishers were maintained for two separate locations: *Main lobby. *Boiler room. Findings include: 1. Observation on 4/11/20 at 9:05 a.m. revealed the fire extinguishers in the boiler room and main lobby had not been signed off on the individual extinguisher tags. Tags must be marked at the individual extinguishers with the initials of the person performing the inspections along with the date of the inspections. Interview at the time of the observations with the maintenance supervisor confirmed those findings. He stated the extinguishers were checked with the provider's preventive maintenance program. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	43A138	A. BUILDING: **01 - MAIN** B. WING	**4/11/2022**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 355	Continued From Page 2
K 712	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 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: 18087 Based on observation, record review, and interview, the provider failed to ensure the fire alarm signal had been transmitted for fire drills. Findings include: 1. Observation on 4/11/22 at 10:15 a.m. revealed the fire alarm was sounded to initiate a drill for a simulated fire in the dining room. At the conclusion of the drill, interview with the maintenance supervisor revealed a call was not made to verify the fire alarm signal had been received by the monitoring agency. He stated those call backs had not been made previously for the drills where the alarm had been sounded. Review of the fire drill records from May 2021 through March 2022 confirmed that finding. The call back verfications needed to be logged with the fire drill information. The deficiency had the potential to affect 100% of the occupants.
K 918	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 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

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 918	Continued From Page 3

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: 18087
Based on observation, record review and interview, the provider failed to ensure:
*The generator battery terminals were covered.
*The generator battery conductivity had been tested and logged monthly.
*The generator was run under load for a minimum of one-half hour monthly with a minimum cooldown time of five minutes for two of twelve months (April and May 2021). Findings include:

1. Observation on 4/11/22 at 9:00 a.m. revealed the generator battery terminals were not covered. Interview with the maintenance supervisor revealed he was unaware the generator battery terminals needed to be covered.

2. Record review on 4/11/22 at 10:20 a.m. revealed the generator battery conductivity was not logged monthly. Interview with the maintenance supervisor revealed he was unaware of the requirement to test the battery monthly.

3. Record review on 4/11/22 at 10:25 a.m. revealed the monthly generator load runs were not documented for the months of April and May for 2021. Interview with the maintenance supervisor revealed he was unaware of the missing documentation for those dates.

The deficiency had the potential to affect 100% of the building occupants.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68814	A. BUILDING: _____ B. WING _____	04/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 41895 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/4/22 through 4/6/22. Medicine Wheel Village was found not in compliance with the following requirements: S206, S236, and S301.	S 000		
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.	S 206		

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

TITLE: Licensed Nursing Facility Administrator

(X6) DATE: 4/28/2022

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68814	A. BUILDING: _____ B. WING _____	04/06/2022

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S 206	Continued From page 1 Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41895 Based on interview and review of employee files and personnel training transcripts, the provider failed to ensure four of five (H, I, J, and L) employees had completed the required training during orientation or annually. Findings include: 1. Review of files and personnel training transcripts showing completion of the required subjects during the past year revealed: *Certified Nursing Assistant (CNA) H, hired on 1/6/22, had not completed accident prevention and safety procedures, proper use of restraints, incidents and diseases subject to mandatory reporting, and dining, nutrition risks, and hydration. *CNA I, hired on 9/28/21, had not completed accident prevention and safety procedures, proper use of restraints, incidents and diseases subject to mandatory reporting, and dining, nutrition risks, and hydration. *Licensed practical nurse J, hired on 8/4/21, had not completed accident prevention and safety procedures and dining, nutrition risks, and hydration. *Dietary aide L, hired 11/23/21, had not completed accident prevention and safety procedures, proper use of restraints, incidents and diseases subject to mandatory reporting, and dining, nutrition risks, and hydration. Interview on 4/6/22 at 3:15 p.m. with administrator A revealed she had agreed all staff had not completed the required training.	S 206	All Medicine Wheel Village Employees will complete the required personnel training by 5/11/2022 with Relias online training and all staff inservice on 5/3/2022 conducted by Medicine Wheel Village Administrator. Audits for New Hire and Annual training to be completed by Staff Development RN weekly times 8 weeks and monthly times 12 months for all employees for completion of required subject training upon hire and Annually. Staff Development RN will report to QAPI monthly. 4/28/2022 DA	5/11/2022

South Dakota Department of Health

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S 236	Continued From page 2	S 236		
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 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: 41895 Based on personnel file review and interview, the provider failed to ensure two of five sampled employees (I and L) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being	S 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 236	Continued From page 3 hired. Findings include: 1. Review of certified nursing assistant I's personnel file revealed: *She was hired on 9/28/21. *She had a negative TB skin test on 10/1/21. *There was no documentation of a second TB skin test. Review of dietary aide L's personnel file revealed: *She was hired on 11/23/21. *She had a negative TB skin test on 4/1/22. *There was no documentation of a two-step TB skin test upon hire. Interview on 4/6/22 at 3:15 p.m. with administrator A and licensed practical nurse J revealed all employees should have a two-step TB skin test upon hire. Review of the provider's August 2013 Tuberculosis Screening - Administration and Interpretation of Turberculin Skin Tests policy revealed: *"The facility will administer and interpret tuberculin skin tests (TST) in accordance with recognized guidelines and pertinent regulations." *It had not specified a timeline of when the TST was to be administered or completed.	S 236	All Medicine Wheel Village employees will complete the required Tb screening for healthcare employees upon hire and annually. The Staff Development RN will audit all employee files weekly times 8 weeks and monthly times 8 months and report audit findings to QAPI. 4/28/2022 DA Medicine Wheel Village Policy for Tuberculosis Screening will be updated to include the 14 day timeline for administration or completion of tb testing for all employees. 4/28/2022 DA	5/11/2022 5/11/2022
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature	S 301		

South Dakota Department of Health

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	68814	A. BUILDING: _____ B. WING _____	04/06/2022

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S 301	Continued From page 4 controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41895 Based on interview and record review, the provider failed to ensure all of the required dietary training's (food safety, handwashing, food handling/prep, food-borne illness, serving and distribution, leftovers, time/temp controls, nutrition/hydration, and sanitation) were completed by all dietary staff. Findings include: 1. Interview on 4/6/21 at 10:30 a.m. with dietary manager C revealed: *She did not know if the dietary staff had completed the required training. *Stated to ask administrator A if they had completed the required training. Interview on 4/6/21 at 11:30 a.m. with administrator A revealed the dietary staff had not completed the required training.	S 301	The Dietary Manger will complete training for all dietary employees on the required training topics on 5/4/2022. Dietary Manger will complete Audits for the completion of required topics for current and new dietary employees monthly times 12 months and report findings to QAPI 4/28/2022 DA	5/11/2022
S 000	Compliance/Noncompliance Statement Surveyor: 41895 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 4/4/22 through 4/6/22. Medicine Wheel Village was found in compliance.	S 000		