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 _____	08/03/2023

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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/1/23 through 8/3/23. Medicine Wheel Village was found not in compliance with the following requirements: F804, F812, and F880.	F 000		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and diet manual review, the provider failed to: *Preserve the nutritive value of pureed foods for two of two sampled residents (5 and 8) by thinning the food items with plain water. *Provide a pureed substitute for a menu item of similar nutritive value for two of two sampled residents (5 and 8) who required a pureed diet for one of one observed meal service. Findings include: 1. Observation and interview on 8/2/23 from 4:18 p.m. to 5:32 p.m. with dietary staff in the kitchen revealed: *The menu for supper that day consisted of one cup shepherd's pie, one-half cup mixed vegetables, a brownie, and a dinner roll.	F 804		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deb Arbogast
TITLE: Licensed Nursing Facility Administrator
(X6) DATE: 8/23/2023

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 804	Continued From page 1 *Cook F scooped about one and one-half cups of shepherd's pie into the blender. -She added about one-quarter to one-half cup of hot water to the blender. *She stated her goal for consistency was similar to yogurt, yet not too runny like soup. *She blended the shepherd's pie and water until it was smooth, yet it was runny. *She portioned the pureed shepherd's pie into two 5.5-ounce (oz.) clear plastic cups, filling the cups to the top. *She stated they usually serve about 5.5-oz. of the main pureed dish, 4-oz. of the side, and either a yogurt cup or a protein gelatin cup for dessert. *Cook F grabbed a clean blender and scooped about one and one-half cups of mixed vegetables into the blender. -She added about one-quarter cup of hot water, and two packets of liquid food thickener to the blender. --The food thickener label read, "simplythick EasyMix Instant Food Thickener, Mildly Thick, Nectar Thick." --The directions read, "Add to 4 fl. oz. [fluid ounces] of liquid. Stir briskly for 30 seconds." *She blended the vegetables until it was smooth, then she portioned the pureed vegetables into two 5.5-oz. clear plastic cups, filling the cups to the top. *Cook F indicated she was trained to use hot water for pureeing foods. -Sometimes she used milk for hot cereals and some desserts. *She had not pureed the brownie or the dinner roll for the supper meal service. *She prepared the plates of pureed food for residents 5 and 8 by grabbing two separate plates and placed the following onto each plate: -The clear plastic cup of pureed shepherd's pie.	F 804		

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F 804	Continued From page 2 -The clear plastic cup of pureed mixed vegetables. -A strawberry yogurt cup in place of the brownie. --The yogurt had visible chunks of strawberries. -She had not provided a pureed alternate for the dinner roll. *She approved the plates that were to have been delivered to the residents. *When questioned about the strawberry yogurt, she had assumed the small chunks of strawberries were acceptable for a pureed diet. -She then replaced the strawberry yogurt with vanilla yogurt, which was smooth. *She again approved the plates and dietary aide S delivered those plates to residents 5 and 8. -There was no pureed alternate for the dinner roll. *When questioned about a pureed menu extension or a diet manual, cook F indicated she was not aware if they had either. Interview on 8/2/23 at 5:52 p.m. with dietary manager (DM) E about the above observations revealed: *They had no specific menu extension for the pureed diets. *She was not aware if there was a diet manual. -She instead brought the manual for food service policies and procedures, which had no descriptions of how to properly puree foods. *She expected staff to use milk for pureeing foods like cereal, and water for pureeing other foods. *She was not aware that water was not the proper liquid to use when pureeing food. -She agreed that water might lessen the flavor. Continued interview on 8/3/23 at 9:28 a.m. with DM E about pureed diets revealed: *She had spoken with registered dietitian	F 804		

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F 804	Continued From page 3	F 804		

consultant (RD) J about a pureed diet menu extension and RD J had indicated using the provider's copy of the Becky Dorner & Associates Diet and Nutrition Manual.
-RD J had to explain to her where to find the diet manual, as she was not aware of it.

Interview on 8/3/23 at 9:33 a.m. with RD J about the above observations revealed:
*It was her expectation that staff should have used broth, gravy, milk, juice, or other liquids with nutritional value to puree foods.
*The texture of the pureed foods should have been similar to mashed potatoes or pudding.
*It was not the best practice to puree foods with plain water as it would alter the taste and decrease the nutritional value of the food.
*She agreed the yogurts with chunks of fruit was not appropriate for someone who required a pureed diet.
*She expected staff to provide pureed food for each item on the menu.
*She said that the dietary staff should have provided an alternate for the dinner roll.
-She indicated that the staff could have pureed the brownie with milk to make a pureed dessert, and the dinner roll with milk to make a slurried bread product.
*She had not created a pureed menu extension.
-It was her expectation for the dietary staff to utilize the diet manual for appropriate pureed alternates and serving suggestions.

Review of resident 5's medical record revealed:
*His diet order changed to pureed on 7/10/23.
*He had not experienced significant weight loss in 30 or 180 days.

Review of resident 8's medical record revealed:

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F 804	Continued From page 4 *On 7/28/23, her diet order was entered as "Consistent Carbohydrate diet, Pureed texture, Nectar consistency." -The directions on the order read verbatim, "Arginaid BID [twice a day] till wound healed. for Due to difficulty chewing." *She weighed 152# (pounds) on 1/29/23. *She weighed 144.2# on 7/31/23. -From 1/29/23 to 7/31/23, her weight decreased 7.8#, that was 5.15% weight decrease. --A decrease of 10% or greater in 180 days was considered significant. Review of the provider's 2014 copy of the "Diet and Nutrition Manual" by Becky Dorner & Associates, Inc. revealed: *There was a section titled "Consistency Altered Diets." *Under the sub-section titled "Dysphagia Puree (Level 1) Diet," -"All foods are pureed to simulate a soft food bolus, eliminating the whole chewing phase." -For protein foods, "5-6 oz equivalent" was the recommended "amount each day." -For vegetables, "[greater than or equal to] 2 [and] 1/2 cups or equivalent" was the recommended "amount each day." -For grains, "[greater than or equal to] 6 oz equivalent" was the recommended "amount each day." -"All foods must be the consistency of moist mashed potatoes or pudding." -"Pureed Diet menus follow the foods on the Regular Diet as closely as possible with the main difference being food consistency." *Under the "Foods Allowed" chart: -"Meats, eggs, and cottage cheese should be pureed to moist, pudding-like consistency..." -"Fruits, include any that are pureed to a smooth	F 804	Medicine Wheel Village is adding the US Foods Blue Print Menu Press which does have the Pureed Menu option. US Foods Blue Print Menu Press has been printed with all menu cycles , snacks and Pureed Menu and is available to all Dietary employees in the kitchen. Dietician has been submitted these Menus and request to sign off on Menus. Procedure for Menus updated to include US Foods Blue Print Menu Press. All Dietary employees will be trained by Dietary manager by 9/17/2023. The Dietary Manager will audit all pureed foods for appropriate consistency for Pureed Menu items , weekly times 4 weeks and monthly times 11 months and report to QAPI monthly. 8/31/2023DA	9/17/2023

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F 804	Continued From page 5 consistency with no pulp, seeds, skins or chunks." *"All foods are the consistency of moist mashed potatoes or pudding." *The diet manual had no directions on how to properly puree foods.	F 804		
F 812 SS=E	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: Based on observation, interview, and policy review, the provider failed to ensure: *Two of three dietary staff (F and S) had performed proper hand hygiene and glove use during one of one meal service observation. *Potentially hazardous food was stored according to the manufacturer's guidelines. Findings include:	F 812		

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F 812	Continued From page 6 1. Observation on 8/1/23 at 9:46 a.m. in the kitchen revealed: *There was a clear plastic container of butter packets sitting on one of the counters. -The container felt like it had been sitting at room temperature, as it was not cold. Observation and interview on 8/2/23 from 4:18 p.m. to 5:32 p.m. with dietary staff in the kitchen revealed: *During the entire meal service observation, dietary aide S had not washed his hands. -He would instead change his gloves between tasks. *Dietary aide S had been wearing gloves while sweeping, then he started to put away clean dishes without changing gloves or performing hand hygiene. *Cook F had asked him to cut the brownies. Dietary aide S had not performed hand hygiene or changed his gloves after sweeping the floor and putting away the dishes. *While wearing those same potentially soiled gloves, dietary aide S had been cutting the brownies and his hands touched the brownies several times. -At one point, he had used the fingers on his left gloved hand to wipe off the brownie crust from the knife, and placed that brownie crust back onto the pan of brownies. *He changed his gloves without performing hand hygiene after he was finished cutting the brownies. -He blew air into each glove to inflate them prior to donning the gloves. *He started to set up the plates for supper service. -During that process, he walked from the kitchen	F 812		

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F 812	Continued From page 7 to the dining room several times and touched the door each time he walked in and out. -He had not performed hand hygiene or changed his gloves. *Cook F prepared the pans of food for supper service. -She performed hand hygiene and donned a new pair of gloves prior. -The meal was shepherd's pie or a hot stuffed pepper, mixed vegetables, a brownie, and a dinner roll with a butter packet. -She had a spatula for the brownies, a measuring scoop for the vegetables, a pair of tongs for the peppers, and another measuring scoop for the shepherd's pie. -There was no serving utensil for the dinner rolls. *With her right gloved hand, she would touch the tongs, the spatula, and the measuring scoops. *With her left gloved hand, she would touch the plates, the brownies, the dinner rolls, and the butter packets. -The butter packets were stored in the clear plastic container. *Several times throughout the observation, she used both gloved hands to touch the food cart, the door handle to the warmer, the brownies as they had been stuck together, and the dinner rolls to open them up. *She had not changed her gloves or performed hand hygiene during the meal service. Continued interview with cook F and dietary aide S after the meal service had finished revealed: *Cook F confirmed that the butter packets were stored on the counter at room temperature. *She was not aware that the label on the packets of "whipped spread" had read "perishable, keep refrigerated." *She usually would have used a serving utensil	F 812	Dietary Manger will educate/reducate all employees in Dietary on appropriate use of gloves and handwashing in the kitchen and dining room by 9/17/2023. Documentation of training and employees who have completed education will be tracked by Dietary Manager with Statement of date of training ,education agenda and attendance of dietary employees. Policy reviewed: Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices. Dietrary Manager will complete weekly audits times 4 weeks and monthly audits times 11 months. Audit findings will be reported monthly to QAPI. 8/31/2023 DA	9/17/23

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F 812	Continued From page 8 for each food item on the menu. -She stated that she was trying to get through the meal service as quickly as possible, so she used her gloved hands to serve the brownies and the dinner rolls. -She agreed she should not have done that. *Dietary aide S said he "knew better," and he agreed he should have washed his hands and changed his gloves between each task. Interview on 8/2/23 at 5:52 p.m. with dietary manager (DM) E about the above observations revealed: *It was her expectation for staff to use a different utensil for each food item during meal service. -Staff should not have touched the food with their potentially contaminated gloves. *She agreed staff should have been performing hand hygiene and changing gloves between each task. *She was aware that the butter packets were stored at room temperature because, "it gets too hard to spread when it's refrigerated." -She was not aware that the label on the "whipped spread" had read "perishable, keep refrigerated." Review of the provider's 2017 "Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices" policy revealed: *"Policy Statement: Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness." *"1. All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working	F 812	All Medicine Wheel Village Dietary employees will be educated/reeducated by the Dietary Manager to check the food label for recommendations for food storage by 9/17/2023. Documentation of training and employees who have completed education will be tracked by Dietary Manager with Statement of education agendaand attendance of training, education agenda and attendanceof training of dietary employees. Dietary Manager educated by Medicine Wheel Village Administrator of Survey findings on 8/16/2023 when survey results received. Audits will be completed weekly times 4 weeks and monthly times 11 months by the Dietary Manger and reported to QAPI. 8/31/2023 DA	9/17/23

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F 812	Continued From page 9 with food or serving food to residents." *"6. Employees must wash their hands:" -"c. Whenever entering or re-entering the kitchen;" -"d. Before coming in contact with any food surfaces;" -"f. After handling soiled equipment or utensils;" -"g. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/or" -"h. After engaging in other activities that contaminate the hands." *"9. Food service employees will be trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness." *"10. Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of disposable gloves does not substitute for proper handwashing." Review of the provider's 2014 "Food Receiving and Storage" policy revealed: *"Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices." *"9. Refrigerated foods must be stored below 41 [degrees Fahrenheit] unless otherwise specified by law." *The policy had not indicated anything about following the manufacturer's labels for proper storage.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		

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F 880	Continued From page 10 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 11 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure nursing staff followed physician orders for oxygen use and nebulizer tubing changes for six of six sampled residents (16, 2, 30, 23, 8, and 9) who received oxygen and nebulizer therapy. Findings include: 1. Observation on 8/1/23 at 1:06 p.m. in resident 16's room revealed: *The resident was lying in bed with his eyes closed, oxygen on, and his oxygen concentrator set at two liters via a nasal cannula.	F 880		

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F 880	Continued From page 12 *His oxygen concentrator had a canister that contained water to humidify the oxygen with a handwritten date of 6/29/23. *The oxygen tubing was not marked with a date. *His nebulizer machine was placed on top of a dresser with the tubing and mask placed directly on top of the machine. -There was no date on the nebulizer tubing and that tubing was not stored in a plastic bag. Additional observations on 8/2/23 at 9:05 a.m. and again on 8/2/23 at 3:03 p.m. in resident 16's room revealed: *Oxygen tubing and the concentrator was in the same condition as above with a date of 6/29/23 on the water canister of the oxygen concentrator. *Nebulizer machine and tubing in the same position and condition as above. The date of 6/29/23 indicated that it had not been changed for four weeks, yet all weekly entries had been initialed by staff as changed on the treatment administration record (TAR) for July 2023. Review of resident 16's electronic medical record (EMR) revealed: *His diagnoses included chronic obstructive pulmonary disease (COPD), history of malignant neoplasm of the bronchus and lung, history of chronic pulmonary embolism, hypoxemia, history of Covid-19, traumatic brain injury, depression, and dementia with behavioral disturbance. *His medications included the following: -Albuterol Sulfate Hydrofluoroalkane Aerosol Solution 108 micrograms (mcg): inhale two puffs orally every four hours as needed for shortness of breath (SOB) related to COPD. -Budesonide-Fomoterol Fumerate Aerosol 160-4.5 mcg: inhale two puffs orally one time a	F 880		

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	43A138	A. BUILDING _____ B. WING _____	08/03/2023

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MEDICINE WHEEL VILLAGE	24266 AIRPORT ROAD EAGLE BUTTE, SD 57625

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F 880	Continued From page 13 day related to COPD. -Ipratropium Albuterol Solution 0.5-2.5 milligram (mg) 1 applicator inhale orally via a nebulizer every four hours as needed for SOB and or wheezing for COPD. -Two liters of oxygen via nasal cannula to keep saturations above 92 percent; oxygen concentrator set at two liters every day and night shift related to COPD with exacerbation. *A 7/28/22 physician's order to replace the oxygen baggie, tubing, humidifier bottle with distilled water and mark with date and initial. Clean the oxygen concentrator. Clean the nebulizer and change tubing every night shift on Thursday's. *He had an acute upper respiratory infection diagnosed on 3/18/23. The resident was seen by his physician and diagnosed with an acute respiratory infection and placed on a steroid and an antibiotic due to increased SOB.. Review of resident 16's July 2023 Treatment Administration Record (TAR) revealed: *Nebulizer tubing, oxygen tubing, water canisters, and plastic bags for tubing storage had been initialed by staff as changed on the following dates: -7/6/23. -7/13/23. -7/20/23. -7/27/23. Interview on 8/2/23 at 3:53 p.m. with certified nursing assistant (CNA) Z regarding the procedure for nebulizer tubing, oxygen tubing, and concentrator water canister changes revealed: *The night nurses were responsible to ensure the nebulizer tubing, oxygen tubing and water	F 880		

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F 880	Continued From page 14	F 880		

canisters were changed and dated every Thursday night.
*Normally the nurses added purified water to the concentrator water canisters when low, but the CNAs would if the nurses were busy.
*Every week the nursing staff were to change the oxygen and nebulizer tubing along with the water canister and mark them with the new date.

Interview and observation on 8/2/23 at 5:30 p.m. with licensed practical nurse (LPN) Q regarding the procedure for nebulizer tubing, oxygen tubing, and concentrator water canister changes for resident 16 revealed:
*The day nurses were not responsible for changing and dating the tubing or canisters for all residents with nebulizers and oxygen concentrators.
*The night nurses had that responsibility.
*The tubing and canisters were to have been changed each week on Thursdays for all residents who had used a nebulizer and/or oxygen therapy.
*LPN Q followed the surveyor into the resident 16's room and agreed:
-The nebulizer machine tubing and oxygen tubing was not dated.
-The nebulizer machine tubing was not stored inside a plastic bag.
-The date on the water canister was 6/29/23 which indicated it had not been changed as ordered.
-The TAR should not have been signed off if the physician's order was not followed through as written.

Interview and observation on 8/02/23 at 5:40 p.m. with infection preventionist H regarding the procedure for nebulizer tubing, oxygen tubing,

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F 880	Continued From page 15 and concentrator water canister changes for resident 16 revealed: *She confirmed: -The nebulizer machine tubing had not been dated and placed in a bag to store in between use. -The oxygen tubing had not been dated to indicate when it had last been changed. -The water canister had a date of 6/29/23 which indicated it had not been changed for four weeks. *The resident had COPD, a history of lung cancer and pneumonia and it would have been important for his nebulizer tubing, oxygen tubing, and water canisters to have been changed as ordered because of his vulnerable lungs. *Her expectation would have been for nursing staff to follow the physician's order and the procedures for changing and dating the nebulizer tubing, oxygen tubing, and water canisters weekly and then initial the TAR when the order was completed. Interview on 8/3/23 at 1:29 p.m. with director of nursing (DON) B regarding resident 16's oxygen tubing, nebulizer tubing and oxygen concentrator canister revealed: *She was not aware of resident 16's physician's orders had not been followed. *The procedure was for the nursing staff to change the nebulizer tubing, oxygen tubing, and concentrator water canisters for each resident with nebulizers and oxygen therapy each week. *Nebulizer and oxygen tubing should have been placed inside a plastic bag when not in use for proper storage in between use. *She agreed that the 6/29/23 date on resident 16's water canister would indicate it had not been changed as ordered and had been missed for four weeks.	F 880		

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F 880	Continued From page 16 *The TAR should not have been initialed by staff if it had not been completed. 2. Observation on 8/2/23 at 5:55 p.m. of resident 2's oxygen concentrator revealed: *The oxygen tubing was draped on top of the oxygen concentrator. *The nasal cannula tubing was not dated or stored in a bag when not in use. Review of resident 2's EMR and TAR revealed: *There was a physician's order for, "Oxygen at two liters per nasal cannula to keep saturations greater than 90 percent every two hours as needed for shortness of breath to keep saturations above 90 percent." *No physician's order was found for changing the nasal cannula tubing. 3. Observation and interview on 8/1/23 at 11:30 a.m. with resident 30 regarding the nebulizer treatments revealed: *She had used the nebulizer to help with her breathing since she had part of her left lung removed. *The nebulizer machine had been setting on top of her dresser with other personal items. *The nebulizer setup was lying on top of the machine. *The nebulizer setup and tubing was not dated. Review of resident 30's EMR and July 2023 TAR regarding nebulizer treatment and tubing changes revealed: *She had a physician's order for an albuterol nebulizer 0.63 % every six hours as needed for shortness of breath.	F 880		

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F 880	Continued From page 17 *There was no order to "replace oxygen baggie, tubing, humidifier bottle with distilled water and mark with date and initials." *"Clean oxygen concentrator. Clean nebulizer and change tubing also every night shift on Thursday." *She had no documented change regarding her tubing. Interview on 8/2/23 at 2:47 p.m. with staff development/infection preventionist H regarding the above resident's oxygen and nebulizer tubing changes revealed: *The oxygen and nebulizer tubing should have been changed every Thursday on the night shift. *Staff should have dated and initialed the baggie and the tubing at the time it was changed. *The oxygen tubing should have been placed in the baggie when not in use. 4. Observation on 8/2/23 at 5:55 p.m. of resident 23's oxygen concentrator revealed: *Oxygen canister contained water to humidify the oxygen and was dated 6/29/23. *Oxygen tubing was discolored and coiled on top of the concentrator. *Oxygen tubing was not dated and had not been placed in a baggie when not in use. Review of resident 23's EMR and June and July 2023 TAR revealed: *She used oxygen at two liters per nasal cannula at night and oxygen at two liters per nasal cannula to keep oxygen levels greater than 90%. *She had a physician's order to "replace oxygen baggie, tubing, humidifier bottle with distilled water and mark with date and initials." *"Clean oxygen concentrator. Clean nebulizer and change tubing also every night shift every on Thursday."	F 880		

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F 880	Continued From page 18 *There was documented completion of the above order that had been initialed by staff on 6/29, 7/6, 7/13, 7/20, and 7/27/23. 5. Observation on 8/2/23 at 5:55 p.m. of resident 8's oxygen concentrator and oxygen tubing revealed: *The oxygen tubing had been coiled and was setting on top of the concentrator. *The oxygen tubing was not dated and was not placed in a baggie when not in use. Review of resident 8's EMR and July 2023 TAR revealed: *The oxygen had been ordered at two liters per nasal cannula to keep oxygen levels above 89%. *There was a physician's order to "replace baggie, tubing, humidified bottle with distilled water and make with initials." *"Clean oxygen concentrator every night shift on Thursday." *There was documented completion of above order that was initialed by staff on 7/6, 7/13, 7/20, and 7/27/23. 6. Observation on 8/2/23 at 5:55 p.m. of resident 9's oxygen concentrator and oxygen tubing revealed: *The oxygen tubing was lying on the floor next to the oxygen concentrator. *The oxygen tubing had not been dated or in a baggie while not being used. Review of resident 9's EMR and July 2023 TAR revealed: *She had a physician's order for oxygen at two liters continuously at night and at two liters as needed to keep oxygen levels greater than 90%. *She had an order to "replace baggie, tubing,	F 880		

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F 880	Continued From page 19 humidified bottle with distilled water and make with initials." *"Clean oxygen concentrator every night shift on Thursday." *There was documented completion of above order that was initialed by staff on 7/6, 7/13, 7/20, and 7/27/23. Interview on 8/3/23 at 1:26 p.m. with director of nursing (DON) B regarding following physician's orders for changing oxygen and nebulizer tubing revealed: *She was not aware that staff had not been initialing and dating the tubing and baggies. *She stated that they should have followed up and ensured the orders had been followed. *She stated that she had entered the resident's rooms who used oxygen and she admitted she noticed that there were no baggies to store oxygen tubing when not in use. *Staff should have followed the physician's orders and the policy. *The policies were available for all staff to access and follow. Interview on 8/3/23 at 2:11 p.m. with administrator A regarding the orders for oxygen and nebulizer tubing changes revealed: *She had spoken to DON B about the physician's orders that were placed on the residents TAR. *"If oxygen and nebulizer tubing change orders had been written on the TAR, staff need to follow the order." Review of the provider's undated Respiratory Therapy Prevention of Infection related to oxygen administration revealed: *Change the oxygen cannula and tubing every seven days and as needed.	F 880	Medicine Wheel Village Administrator , DON, MDS Coordinator and Housekeeping Supervisor with the Medical Director guidance did review current policy and procedure for oxygen/ nebulizer tasks and all staff education to be completed on 8/28/2023 by Medicine Wheel Village Administrator. All residents who receive oxygen therapy and nebulizer treatments as well as staff have potential to be affected by lack of appropriate processess and follow through for the above identified items. Policy education/reeducation regarding roles and responsibilities for the above assigned tasks will be identified assigned care and services tasks will be provided by Medicine Wheel Village Administrator on 8/28/2023. Medicine Wheel Village employees who provide or are responsible for the care of oxygen and nebulizer care and services will be educated/reeducated on 8/28/2023 for Oxygen cares and Nebulizer treatments by Medicine Wheel Village administrator.	

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F 880	Continued From page 20 *Store the tubing in a plastic bag, marked with the date and resident's name between use. *Keep the oxygen cannula and tubing used prn {as needed} in a plastic bag when not in use. *Store the nebulizer "set-up" in a plastic bag , marked with the date, and resident's name between use. *Discard administration "set-up" every seven days.	F 880	Medicine Wheel Village Administrator, DON, MDS Coordinator and RN Staff Development will ensure all facility staff responsible for the assigned tasks have received education and training with demonstrated competency and documentation. Medicine Wheel Village Administrator contacted SD QIN on 8/16/2023 to determine the root cause analysis for the ommission of changing and cleaning oxygen and nebulizer equipment per policy and physican order for the assigned tasks. 5 whys of Areas looked at were need for reeducation for infection control, time frame of assigned task, assignment on Etar for tasks, who is responsible for assigned tasks of oxygen/ nebulizer tasks, availability of equipment and communication if equipment not available. Medicine Wheel Village Administrator , MDS RN Coordinator, DON and RN Infection Control/Staff Development will complete weekly audits 2-3 times per week for all shifts. Ongoing education and communication for availability of supplies , following policy procedure and signature to e-tar records to assure compliance. DON will report to QAPI Audit results weekly times 4 , monthly for 11 months to QAPI.	08/31/2023

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 8/1/23 through 8/3/23. Medicine Wheel Village was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deb Arbogast
TITLE: Licensed Nursing Facility Administrator
(X6) DATE: 8/23/2023

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 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/3/23. 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 K161, K321, K324, K347, K353, and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered	K 161		

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

TITLE
Licensed Nursing Facility Administrator

(X6) DATE
8/23/2023

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K 161	Continued From page 1 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the building construction type (Type V III construction) in one random location (Room 210). Sheetrock covering was missing for approximately ten square feet from the west wall. Findings include: 1. Observation on 8/3/23 at 8:30 a.m. revealed the west wall of room 210 was missing several sections of 5/8 inch Type X sheetrock (the interior wall fire-rated protection designation of III) at the automatic fire sprinkler location. The missing sections amounted to approximately ten square feet in area, exposing the wood (Type V) construction. Interview with the administrator at the time of the observation confirmed that condition. She	K 161		

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K 161	Continued From page 2 revealed the sprinkler system repair troubleshooting by the sprinkler contractor required the removal of the sheetrock. The deficiency had the potential to affect 100% of the smoke compartment occupants.	K 161	The West wall of room 210 missing sections were replaced with 5/8 Type X sheetrock on 8/9/2023. 8/23/2023 DA	9/17/2023
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 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)	K 321		

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K 321	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain four separate hazardous areas (Storage in rooms 109, 110, 111, and 112) as required. Findings include: 1. Observation on 8/3/23 at 10:15 a.m. revealed resident rooms 109, 110, 111, and 112 were being used for storage due to building infrastructure issues (sprinkler system). The rooms were over 100 square feet in area and held copious amounts of combustible items. The corridor doors were equipped with closers but did not meet more than an equivalent twenty-minute fire-rating (solid bonded wood core doors). The sprinkler system was also not in service in those rooms. Interview with the administrator at the times of the observations confirmed those findings. The deficiency affected two of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment.	K 321	Medicine Wheel Village will rent four portable 8x20 Storage Units and will move all items out of rooms 109, 110,111 and 112. Portable storage units will be obtained and all items moved by 9/17/2023. Maintemance will complete monthly audits that there are no rooms on 100 wing used for storage and report to QAPI times 12 months. 8/23/2023 DA	9/17/2023
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	K 324		

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	43A138	A. BUILDING 01 - MAIN B. WING	08/03/2023

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K 324	Continued From page 4 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: A. Based on document review and interview, the provider failed to conduct the required every six-months inspection of the cooking facility's fire suppression system for the range hood. The records regarding the kitchen hood fire suppression system indicated an inspection had only been completed in April 2023 and April 2022. Findings include: 1. Document review on 8/3/23 at 9:30 a.m. of the kitchen hood fire suppression system records indicated the last two inspections were performed on 4/19/23 and 4/26/22. The kitchen hood fire-suppression system must be inspected not less than every six months. There was no further documentation indicating other required inspections had taken place. Interview with the maintenance manager on 8/3/23 at 9:32 a.m. confirmed that finding. He stated he was a new employee and had just started his employment in June 2023 and was coordinating required	K 324	Kitchen hood fire supression system was inspected and is scheduled for April and October. New documents are being emailed to Medicine Wheel Village. Monthly Audits will be completed by Maintenance and has been updated in TELS system. Maintenance will report monthly to QAPI times 12 months. 8/23/2023 DA	9/17/2023

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 _____	**08/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 324	Continued From page 5 inspections to bring the facility up to date. B. Based on document review and interview, the provider failed to conduct the required every six-months inspection of the exhaust ductwork and ventilator for the range hood. The records regarding the kitchen hood exhaust ductwork had been cleaned June 2022. Findings include: 1. Document review on 8/3/23 at 9:34 a.m. of the kitchen hood exhaust duct inspection records indicated the last cleaning had been performed on 6/20/22. The kitchen hood exhaust ductwork and ventilator must be inspected for grease buildup (or cleaned) not less than every six months. There was no further documentation indicating other required inspections had taken place. Interview with the maintenance manager on 8/3/23 at 9:37 a.m. confirmed that finding. He stated he was a new employee and had just started his employment in June 2023 and was coordinating required inspections to bring the facility up to date. This deficiency affected two of numerous kitchen hood requirements.	K 324	Extreme Cleaning completed the required kitchen hood exhaust duct inspection on 8/14/2023. Maintenance will audit monthly times 12 months and report to QAPI monthly. TELS has been set to alert every 6 month inspections. 8/23/2023 DA	9/17/2023
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the provider failed to maintain one of one fire alarm	K 347		

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 _____	**08/03/2023**

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K 347	Continued From page 6 system as required. Findings include: 1. Record review on 8/3/23 at 8:45 a.m. revealed the annual fire alarm inspection report dated 9/26/22 listed failed smoke detectors at the following locations: *Smoke card one #45 FAIL *Smoke card two #9 FAIL *Smoke card two #40 FAIL. There was no documentation indicating the failed smoke detectors had been repaired or replaced. Interview with the maintenance manager at the time of the record review confirmed those findings. He stated he was a new employee and started his employment in June 2023 and had the fire alarm contractor scheduled to come to the facility in the next month. The deficiency affected 100% of the occupants of those smoke compartments.	K 347	Bancoe is scheduled to return to MWV by 9/17/2023 to fix the failed smoke card #45 , smoke Card #9 and smoke card #40. Audits will be completed by Maintenance monthly times 12 months. Annual Fire alarm inspection is added in TELS system every 12 months and is due in September 2023. Monthly Audits completed will be reported to QAPI times 12 month by Maintenance department. 8/23/2023 DA	9/17/2023
K 353 SS=F	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	K 353		

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K 353	Continued From page 7	K 353		

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:
Based on document review and interview, the provider failed to maintain the automatic fire sprinkler system as required for two of six zones (System unit #3 Zone 3 Wing D and system unit #4 Zone 6). Findings include:

1. Document review on 8/3/23 at 8:30 a.m. revealed the automatic fire sprinkler system report dated 2/8/23 revealed the following:

*The system had not remained fully in service since the prior inspection in 2022
*Not all the fire protection systems were in service without modification since the prior inspection in 2022
*The system had not been free of actuations or alarms since the prior inspection in 2022
*The wet system piping was not protected from temperatures below 40 degrees Fahrenheit
*The alarm panel could not be cleared upon leaving

There was no documentation indicating the above noted issues had been corrected.

Interview with the maintenance manager at the time of the record review confirmed those findings. He stated he was a new employee and had just started his employment in June of 2023 and was in the process of arranging for the repair quotes.

9/17/2023

Medicine Wheel Village is consulting with CRST Tribal projects and EAPC. Request for a 6 month extension for installation of a new automatic fire sprinkler system.
8/23/2023 DA

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K 353	Continued From page 8 The deficiency affected 100% of the occupants of those smoke compartments.	K 353		
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 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: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills) for one of four yearly quarters from January 2023 through March 2023. Findings include: 1. Record review at 9:15 a.m. on 8/3/23 revealed there was no documentation for the first, second, or third shift fire drills for quarter one (January, February, and March) in 2023. Interview with the maintenance manager at the time of the record review confirmed those findings. He stated he was a new employee in 2023. The deficiency had the potential to affect 100% of the occupants of the building.	K 712	Medicine Wheel Village Administrator completed education and gave copies of the survey report when received on 8/16/2023 to the maintenance department. TELS has been updated to alert for monthly fire drills for day , shift and night shift. Audits will be completed and reported monthly to QAPI times 12 months by the maintenance department. 8/23/2023 DA	9/17/2023

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South Dakota Department of Health

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	68814	A. BUILDING: _____ B. WING _____	08/03/2023

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

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/1/23 through 8/3/23. Medicine Wheel Village was found not in compliance with the following requirements: S199, S206, S210 and S236.	S 000		
S 199	44:73:04:04 Personnel The facility shall have a sufficient number of qualified personnel to provide effective and safe care. Staff members on duty shall be awake at all times. Any supervisor shall be 18 years of age or older. Written job descriptions and personnel policies and procedures shall be made available to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility shall establish and follow policies regarding special duty or staff members on contract. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review, interview, and policy review, the provider failed to follow their policy to complete background checks for six of six sampled recently hired employees (K, L, M, N, T, and U). Findings include: Review of employee personnel files revealed: *Registered nurse K had been hired on 11/27/22. *Housekeeper L had been hired on 11/12/22. *Cook M had been hired on 3/13/23. *Cook N had been hired on 6/29/23. *Activity Aide T had been hired on 6/11/23. *Certified nursing assistant U had been hired on 11/15/22.	S 199	All Medicine Wheel Village Employees will have a completed background check before first date of employment completed by Staff Development RN and in her absence Human Resources. Policy review completed with Department Heads. New hire Audits will be completed weekly times 4, monthly times 12 and reported to QAPI by Human Resources and or Staff Development RN. Staff Development RN will report monthly to QAPI. Staff Development RN and all Department Heads educated on background check requirements on 8/16/2023. 8/31/2023 DA	9/17/2023

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

TITLE: Licensed Nursing Facility Administrator

(X6) DATE: 8/23/2023

South Dakota Department of Health

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S 199	Continued From page 1 Interview on 8/2/23 at 1:00 p.m. with staff development/infection preventionist H regarding the above employee files revealed: *She had been new to her position. *She was the person responsible to ensure employee files were completed with all the required documents and training, including background checks. *It was the policy to complete background checks on all hired employees. *She agreed the above employees had not had a background check completed prior to their start date. Review of the provider's undated New Employee Hiring Process Guidelines revealed: *The following documents were to be included in the employee personnel files: -Background check. -Employee health assessment. -TB screening record. -New employee orientation checklist of education.	S 199		
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;	S 206		

South Dakota Department of Health

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S 206	Continued From page 2 (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 facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview, the provider failed to ensure all require training topics had been completed for six of six sampled employees (K, L, M, N, T, and U) within 30 days of their hire date. Findings include: 1. Review of registered nurse K's employee file revealed: *She had been hired on 11/27/22. *There was no documentation she had completed training for the following required topics within 30 days of her hire date: -Proper restraint use. 2. Review of housekeeper L's employee file revealed: *He had been hired on 11/12/22. *There was no documentation he had completed	S 206		

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S 206	Continued From page 3 any of his required training within 30 days of his hire date: 3. Review of cook M's employee file revealed: *He had been hired on 3/13/23. *There was no documentation he had completed training for the following required topics within 30 days of his hire date: -Accident prevention/safety measures. -Proper restraint use. -Resident rights. -Confidentiality of resident information. -Incidents/disease reporting. -Care of residents with unique needs. -Abuse, neglect, misappropriation, mistreatment. -Nutrition/hydration (dietary). -Sanitation (dietary). 4. Review of cook N's employee file revealed: *She had been hired on 6/29/22. *There was no documentation she had completed training for the following required dietary training topics within 30 days of her hire date: -Food safety. -Handwashing. -Food handling/preparation. -Foodborne illness. -Serving/distribution. -Leftovers. -Time/temperature controls. -Nutrition/hydration. -Sanitation. 5. Review of activity aide T's employee file revealed: *He had been hired on 6/11/23. *There was no documentation he had completed training for the following required topics within 30 days of his hire date: -Fire prevention/response.	S 206		

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S 206	Continued From page 4 -Emergency procedures/preparedness. -Infection control/prevention. -Dining assistance/nutritional risks/hydration. 6. Review of certified nursing assistant U's employee file revealed: *She had been hired on 11/15/22. *There was no documentation she had completed training for the following required topics within 30 days of her hire date: -Fire prevention/response. -Accident prevention/safety procedures. -Proper restraint use. -Resident rights. -Incidents/disease reporting. -Dining assistance/nutritional risks/hydration. Interview on 8/2/23 at 1:00 p.m. with staff development/infection preventionist H regarding the above employee files revealed: *She was new to her position. *She was the person responsible to ensure employee files were completed with all the required documents and training, including background checks. *It was the policy to complete all required orientation training for hired employees. *She agreed not all of the required education had been completed within 30 days of the employee's hire date. *Her expectation was to follow the state regulation for all required training topics. Review of the provider's undated New Employee Hiring Process Guidelines revealed: *The following documents were to have been included in the employee personnel files: -Completed employee orientation checklist of required education.	S 206	All trainings were completed by employees N , T and U and current Medicine Wheel Village Employees will complete the required personnel training by 9/6/2023 with Relias online training and all Staff inservice by Staff Development RN on 8/28/23 via Zoom. Employees K , M and L are no longer employed at Medicine Wheel Village. Audits for New Hire and Annual training to be completed by Staff Development RN weekly times 4 weeks for all employees for completion of required new hire and Annual training and monthly times six months. Policy review completed with no revision to Policy. All Audit findings to be reported monthly to QAPI by Staff Development RN. Staff Development RN and all Department Heads were educated of required training by Medicine Wheel Village Administrator when Survey findings were received on 8/16/2023. 8/31/2023 DA	9/17/2023

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S 210	Continued From page 5	S 210		
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: Based on personnel file review, interview, and new employee hiring process guidelines, the provider failed to ensure six of six sampled employees (K, L, M, N, T, and U) were evaluated by a licensed health professional and determined to have been free from reportable communicable disease within fourteen days after the start of their employment. Findings include: Review of employee personnel files revealed: *Registered nurse K had been hired on 11/27/22. *Housekeeper L had been hired on 11/12/22.	S 210		

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S 210	Continued From page 6 *Cook M had been hired on 3/13/23. *Cook N had been hired on 6/29/23. *Activity Aide T had been hired on 6/11/23. *Certified nursing assistant U had been hired on 11/15/22. *None of the above employees had been evaluated by a licensed health professional and determined to have been free from reportable communicable diseases within fourteen days after the start of their employment. *The health evaluation forms that were used by the provider had not included a statement that the employee had been free from reportable communicable diseases or a line for the licensed health professional's signature. Interview on 8/2/23 at 1:00 p.m. with staff development/infection preventionist H regarding the above employee files revealed: *She was new to her position. *She was the person responsible to ensure employee files were completed with all the required documents and training, including health screenings performed by a licensed health professional. *It was the policy to complete health screenings on all newly hired employees. *She agreed the above employees had not had a health evaluation completed by a licensed health professional prior to their start dates. *She was unaware the health evaluation forms used were to have included a statement that the employee had been free from reportable communicable diseases with a signature from a licensed health professional. Review of the provider's undated New Employee Hiring Process Guidelines revealed: *The following documents were to be included in the employee personnel files:	S 210	All Medicine Wheel Village employees will complete the revised Medicine Wheel Village Health Assessment form upon hire and Annually. Employees K, L, and M have resigned at Medicine Wheel Village. Employees N, T and U along with all other current employees will complete the annual revised health assessment by 9/17/2023 that includes free from communicable disease and line for RN signature. The Staff Development RN is responsible to complete the revised health assessment form with new hires and annually. Human Resources will audit all employee files for new hires weekly times 8 weeks and monthly times 10 months and report to QAPI. All Department Heads were educated of Survey findings on 8/16/2023 by Medicine Wheel Village Administrator. 8/31/2023 DA	9/17/23

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 _____	08/03/2023

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S 210	Continued From page 7 -Background check. -Employee health assessment. -TB screening record. -New employee orientation checklist of education.	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 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:	S 236		

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S 236	Continued From page 8 Based on personnel file review, interview, and policy review, the provider failed to ensure four of six sampled employees (L, M, T, and U) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include: 1. Review of employee L's personnel file revealed: *He was hired on 11/12/22. *His first TB skin test had been completed on 5/31/23, that was six months past his hire date. *There had been no documentation a second TB skin test had been completed. 2. Review of employee M's personnel file revealed: *He was hired on 3/13/23. *His first TB skin test had been completed on 3/30/23, that was 17 days past his hire date. *There had been no documentation a second TB skin test had been completed. 3. Review of employee T's personnel file revealed: *He was hired on 6/11/23. *His first TB skin test had been completed on 6/18/23. *There had been no documentation a second TB skin test had been completed. 4. Review of employee U's personnel file revealed: *She was hired on 11/15/22. *There had been no documentation a TB skin test or TB screening had been completed. Interview on 8/3/23 at 9:00 a.m. with staff development/infection preventionist H regarding	S 236		

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S 236	Continued From page 9 new employee TB skin test screenings revealed: *She was new to her position. *She was the person responsible to ensure employee files were completed with all the required documents and training, including TB screenings. *It was the policy to complete TB screenings on all newly hired employees. *Since she started her new position, she had performed the first step of the TB screen for new employees. *If the first step revealed no issues, she had not performed a second step TB skin test. *She had followed the TB screening policy. *She was not aware of the requirement to perform the TB screenings by a two-step method of tuberculin skin test or a TB blood assay test. *Her expectation was to follow the state regulation for TB screenings. Review of the revised August 2019 provider's TB employee screening policy revealed: *1. "Each newly hired employee is screened for LTBI (latent tuberculosis infection) and active TB disease after an employment offer has been made but prior to the employee's duty assignment. *2. Screening includes a baseline test for LTBI using either a TST (tuberculosis skin test) or IGRA (interferon gamma release assay blood test), individual risk assessment and symptom evaluation. -a. If the baseline test is negative and the individual risk assessment indicates no risk factors for acquiring TB, then no additional screening is indicated. -b. If the baseline test is positive, but the individual risk assessment is negative and the individual is asymptomatic, a second test (either TST or IGRA) is conducted."	S 236	Medicine Wheel Village Policy reviewed with Staff Development RN and added to all new hire employee packets. Education to Staff Development RN and department heads completed on 8/23/203 by Medicine Wheel Village Administrator. 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 new hires for TB screening completion upon hire and Human resources will audit all current employees for Annual TB screening weekly times 4 weeks and monthly times 11 months and report to QAPI.	9/17/23 9/17/23

South Dakota Department of Health

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S 000	Compliance/Noncompliance Statement 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 8/1/23 through 8/3/23. Medicine Wheel Village was found in compliance.	S 000		