DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-0391

| | | MEDICAID SERVICES | | | | NO. 0930-039 |
|--|---|---|---|---|-----------|--|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDI | FIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
| | | 435033 | B. WING_ | | 1 0 | 8/02/2023 |
| | ROVIDER OR SUPPLIER | RE FACILITY | | STREET ADDRESS, CITY, STATE, ZIP CODE 255 TEXAS ST RAPID CITY, SD 57701 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS | | FC | 000 | | And the second s |
| | with 42 CFR Part 483, for Long Term Care fa | n survey for compliance Subpart B, requirements cilities was conducted from Westhills Village Health d in compliance. | | | | To make the state of the state |
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| | | | TOTAL DATE OF THE PARTY OF THE | | | The second of th |
| the state of the s | | | | | | min day of the banks of the same of the sa |
| delical agreements and proposed account of the second | | | | | | TOTAL THE STATE OF |
| the distribution to the second | | | | | | |
| | Kelsey Berts | | | Executive Director | | 8/4/23 |
| BORATORY DI | RECTOR'S OR PROVIDER/SUI | PPLIER REPRESENTATIVE'S SIGNATURE | | TITLE | | (X6) DATE |

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 of the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions of the facility of the facility. Facility ID: 0003

If continuation sheet Page 1 of 1

SD DOH-OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-0391

| CENTER | RS FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO. 0938-0391 |
|--------------------------|--|--|---------------------|--------------------------------------|---|-------------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED |
| | | 435033 | B. WNG_ | | | 08/02/2023 |
| NAME OF P | ROVIDER OR SUPPLIER | * | | STREET ADDRESS, CITY, STATE, | ZIP CODE | |
| WESTHIL | LS VILLAGE HEALTH CA | ARE FACILITY | | 255 TEXAS ST RAPID CITY, SD 57701 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | (EACH CORRECTIVE CROSS-REFERENCEE | AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY) | |
| E 000 | A recertification surve CFR Part 482, Subpa Emergency Prepared Term Care facilities w | ey for compliance with 42 rt B, Subsection 483.73, ness, requirements for Long as conducted from 7/31/23 nills Village Health Care | EC | DEFIC | | |
| | | | | | | |
| | | | | | | |
| | Kelsey Berts | | | Gecutive Du | rector | 8/4/23 |
| ABORATORY D | IRECTOR'S OR PROVIDER/SU | IPPLIER REPRESENTATIVE'S SIGNATURE | | TITLE | | (X6) DATE |

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 radiity of deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Version

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SD DOH-OLC

Facility ID: 0003

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

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL | | PLE CONSTRUCTION G 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED |
|--|--|--|---------------------|--|-------------------------------|
| | | 435033 | B. WNG | | 08/01/2023 |
| | ROVIDER OR SUPPLIER LS VILLAGE HEALTH CA | RE FACILITY | | STREET ADDRESS, CITY, STATE, ZIP CODE 255 TEXAS ST RAPID CITY, SD 57701 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETION |
| K 000 | Life Safety Code (LSC occupancy) was cond Village Health Care Fa | R 483.70 (a) requirements | K 00 | | |
| | Kelsey Berta | ch | | Executive Director | 8/4/23 |

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 fadility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Event ID: 7BFK21

FORM CMS-2567(02-99) Previou

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Facility ID: 0003

If continuation sheet Page 1 of 1

South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 10721 08/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 255 TEXAS ST **WESTHILLS VILLAGE HEALTH CARE FACILITY** RAPID CITY, SD 57701 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 000 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 7/31/23 through 8/2/23. Westhills Village Health Care Facility was found in compliance. S 000 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 7/31/23 through 8/2/23. Westhills Village Health Care Facility was found in compliance. Kelsey Bertsch

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

TITLE

(X6) DATE

AUG 0 4 2023

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