STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435033	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westhills Village Health Care Facility	255 Texas St Rapid City, SD 57701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure that the current advance directives (a document that expresses a person's health care wishes if they become unable to speak for themselves) for five of five sampled residents (7, 13, 26, 27, and 60) were in the residents' medical records according to the provider's policy.Findings include: 1. Review of resident 7's medical record revealed she admitted to the facility on [DATE]. There was no documentation indicating that any advance directive paperwork, which expressed her wishes regarding her code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop), was completed upon admission. 2. Review of resident 13's medical record revealed she admitted to the facility on [DATE]. There was no advance directive or document that indicated her wishes regarding her code status in her medical record. 3. Review of resident 26's medical record revealed she admitted to the facility on [DATE]. A progress note dated 10/30/25 by executive director (ED) A indicated she had completed admission paperwork with resident 26, including the advance directive information. There was no advance directive in her medical record. 4. Review of resident 27's medical record revealed she admitted to the facility on [DATE]. There was no documentation that the resident completed any advance directive paperwork on admission. There was a progress note on 10/2/25 completed by ED A that stated she had completed admission paperwork with resident 27 that which included advance directive information. 5. Review of resident 60's medical record revealed he admitted to the facility on [DATE]. There was a copy of his admission paperwork, including his baseline care plan in his medical record. That paperwork did not include his advance directive. 6. Interview on 3/11/26 at 3:36 p.m. with interim director of nursing (IDON) B revealed that their process for documenting a residents' advance directive wishes was to identify those wishes on the resident's baseline care plan and to keep that care plan in each resident's medical record for the staff to refer to. She acknowledged that resident 60's baseline care plan did not address his advance directives. She acknowledged that the baseline care plans for several residents were not available because she could not find copies of them or they were removed from the resident's medical record and stored at an offsite location and would have to retrieve them, as part of their record thinning process. She acknowledged that without that documentation in their medical records, the code status or those residents could not be confirmed by the staff to honor those wishes. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Interview on 3/12/26 at 9:56 a.m. with ED A and IDON B revealed that social service coordinator H would review advance directives with the residents upon their admission to the facility. After social service coordinator H would receive the resident's code status from the interview on admission she would document it in the resident's medical record. Within the first week of the resident's admission, medical director G would conduct an initial assessment of the resident and review the resident's advance directives with the resident Social service coordinator H would review the advance directive with the resident during the resident's care conference and make any changes that were needed. ED A stated that she completed the residents' admission paperwork when social service coordinator H when she was out of the facility. 8. Review of the provider's 12/22/14 Advance Directives policy revealed, The Resident's attending physician will be notified of any Advance Directives and documentation of Advance Directives will be maintained in the Resident's permanent record and reviewed routinely or as needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure quality of care for one of one samples resident (27) with hemiplegia (one-sided paralysis) who was not provided a pillow under her arm for support as indicated in her care plan by one of one certified nursing assistant (I).Observation and interview on 3/10/26 at 1:08 p.m. in resident 27's room revealed she was seated in her wheelchair watching television. Her call light was lying on the bed to her left and her left hand was resting in her lap. A sign on the wall behind the resident read, Place a pillow under my left arm when I am up in the wheelchair Due to my Stroke. No pillow was positioned under resident 27's left arm. Resident 27 stated she was unsure when the staff had last placed a pillow under her left arm when she was seated in her wheelchair. 2. Observation on 3/11/26 at 1:30 p.m. revealed resident 27 was sitting in her wheelchair the commons area of the facility. Her left arm was positioned down between her left leg and the left armrest of her wheelchair. There was no pillow observed under her left arm. 3. Review of resident 27's electronic medical record revealed she admitted to the facility on [DATE]. Her 1/8/26 Brief Interview for Mental Status score was 8, which indicated her cognition was moderately impaired. Her diagnoses included hemiplegia following cerebral infarction (paralysis of one side of the body caused by a stroke), and dementia (a group of symptoms affecting memory, thinking, and social abilities). Resident 27's 1/12/26 care plan under the section ADL (activities of daily living) Functional/Rehab Potential dated 1/12/26 indicated: Please support my left arm with a pillow when I am sitting in my wheelchair. 4. Interview on 3/12/26 at 8:07 a.m. with certified nursing assistant (CNA) I in resident 27's room revealed she was aware of the sign posted in resident 27's room. CNA I stated that she believed she had placed the pillow under resident 27's arm on 3/11/26 but later acknowledged she had forgotten to do so. She further stated that the sign was provided by the therapy department and was posted in the room for a couple of months. 5. Interview on 3/12/26 at 8:13 a.m. with director of rehabilitation (DOR) J regarding discharging of a resident from therapy revealed that when a resident was discharged from therapy a Restorative Nursing Referral and Treatment Record form was completed. That form was then to be placed in the restorative binder so that the restorative nursing staff could continue those treatment interventions with the resident. 6. Interview on 3/12/26 at 8:20 a.m. with executive director (ED) A and interim director of nursing (IDON) B revealed minimum data set (MDS) coordinator K initiates the completed Restorative Nursing Referral and Treatment Record form received from the therapy department with the restorative nursing program. After restorative was completed then the MDS Coordinator would add the restorative task to the residents' care plan so the CNAs can begin implementing the new goal. 7. Interview on 3/12/26 at 8:25 a.m. with MDS coordinator K revealed she received resident 27's completed Restorative Nursing Referral and Treatment Record from the therapy department on 12/23/25 and implemented her restorative therapy. She added the restorative task to resident 27's care plan on 1/12/26 for the CNAs to implement. 8. Continued interview on 3/12/26 at 8:29 a.m. with ED A and DON B revealed that the task of placing a pillow under resident 27's left arm while she was in her wheelchair was not added to the resident's medication administration record (MAR) on 1/12/26, would would notify the CNAs to document that they had completed that task. ED A stated that when a new goal was added to a residents' care plan, it was highlighted in yellow to alert the CNAs of a new goal. ED A and DON B both expected the CNAs to follow the residents' care plan.9. Interview on 3/12/26 at 9:45 a.m. with CNA I revealed that she confirmed that a new goal in the residents' care plan was highlighted in yellow to alert the CNAs to a change. 10. Review of the provider's 6/17/25 Care Plan policy revealed: 3. Each resident's comprehensive care plan is designed to: f. As appropriate and applicable, assist in prevention of decline or maintenance of current ability in resident's functional status and/or functional level;

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed standard infection prevention practices regarding urinary catheter (flexible tubing placed in the bladder to drain urine) care according to the provider's policy for one of one sampled resident (56) with her catheter supplies stores in a container on a shared bathroom floor, and lack of hand hygiene by two of two certified nursing assistants (D and F) observed assisting two of two sampled residents (15 and 19) with eating. Findings include:1. Observation on 3/10/26 at 10:05 a.m. in resident 56's room revealed resident 56 was asleep in her bed and shared a bathroom with her roommate. The bathroom door was open and there was an unlabeled pink plastic container on the floor under the sink. That container held a bottle of liquid with the label distilled vinegar, an empty 60cc (cubic centimeter) syringe, and an unlabeled urinary catheter (flexible tubing placed in the bladder to drain urine) urine collection bag. The urine collection bag had a colorless liquid in it and there was no cap placed over the opening of the tubing. 2. Review of resident 56's electronic medical record (EHR) revealed she was admitted to the facility on [DATE]. On 3/7/26 a nurse performed a bladder scan (a noninvasive imaging device that can read the amount of fluid that is in a bladder) and determined that resident 56 was retaining urine. A physician's order to place a urinary catheter was obtained and a nurse placed the urinary catheter. The resident was admitted to the hospital on [DATE] for conditions unrelated to that urinary catheter. 3. Observation on 3/11/26 at 11:08 a.m. revealed that the pink plastic container with urinary catheter supplies was still on the floor under the sink in resident 56's shared bathroom. 4. Interview on 3/11/26 at 3:11 p.m. with certified nurse assistant (CNA) E revealed each resident with a urinary catheter used a night urinary catheter bag and a day urinary catheter bag. The night bag was larger and could hang on the resident's bed so the staff could empty it without disturbing the resident while they slept. The day bag was smaller and attached to the resident's leg under their clothes for privacy.The CNAs were expected to change the day urinary catheter bags to the night urinary catheter bags. The CNA would remove one urinary catheter bag, clean the tubing with an alcohol wipe, and attach the other urinary catheter bag.The removed urinary catheter bag would be emptied and flushed with water. The CNA would then use a 60cc syringe to insert vinegar into that bag, place a cap over the tube to prevent vinegar from leaking out, and store the vinegar-filled bag in a pink plastic container in the resident's bathroom cabinet.CNA E acknowledged that resident 56's urinary catheter bag was not stored correctly because it did not have a cap on the tube and the pink plastic container was on a shared bathroom floor. 5. Interview on 3/11/26 at 3:20 with registered nurse (RN) C revealed the night shift was expected to change out all urinary catheter bags on Saturday nights. They would also be expected to obtain a new 60cc syringe and write the date on the syringe with a permanent marker.She agreed with CNA E that the catheter bag that was not in use by the resident was to be filled with distilled vinegar and stored in the resident's bathroom cabinet.She acknowledged that storing resident 56's urinary catheter bag in a pink plastic container on the floor in a bathroom shared between two residents increased the risk of it being contaminated. She then removed resident 56's urinary catheter supplies from the bathroom floor and disposed of them. 6. Observation on 3/10/25 at 11:24 a.m. in the main dining room revealed CNA F was sitting at a dining table between residents 15 and 19 for the noon meal. She assisted resident 19 to take a bite of food from a spoon that was in CNA F's right hand. She put the spoon down, turned to resident 15, grabbed resident 15's spoon with her right hand and fed resident 15 a bite of food.CNA F continued to assist residents 15 and 19 four more times without washing her hands before or after touching their eating utensil. 7. Observation on 3/10/26 at 4:40 p.m. in the main dining room revealed CNA D scooped up a bite of food onto a fork, fed that bite of food to resident 15 and placed the fork onto resident 15's plate.CNA D then turned to resident 19 and scooped up a bite of food onto her spoon, fed that food to resident 19 and placed the spoon down on resident 19's plate. CNA D did not wash or sanitize her (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands before assisting residents 15 and 19 to eat. 8. Interview on 3/12/26 at 11:45 a.m. with executive director A and interim director of nursing/infection preventionist B revealed they expected the staff to perform hand hygiene between assisting different residents. That expectation included when the staff assisted residents with eating, and when the staff members used the same hand between those residents.They expected staff members to follow the provider's policy for urinary catheter bag cleaning and storage. The pink plastic container with the urinary catheter cleaning supplies should be stored in the cabinet in the resident's bathroom. They expected the 60cc syringe to be dated, and the urinary catheter tubing to have a cap over the tip to keep the inside clean.They acknowledged that storing the urinary catheter cleaning supplies in the pink plastic container on the floor of a shared bathroom could compromise those supplies and they would no longer be considered clean. 9. Review of the provider's 3/16/16 Catheter Care policy revealed the catheter bags were to be cleaned daily. The procedure for cleaning the bag included instructions for the staff to empty the urine from the bag and then to pour [an] adequate amount of cleaning solution consisting of one part vinegar to four parts water into a graduated cylinder. Using a large syringe, instill the solution into the tubing and allow [it] to flow into the bag. Rinse [the] solution around in [the] bag and tubing and allow to sit for a minimum of one hour. Empty [the] solution and store bag. The syringe will be dated and changed on a weekly basis along with the day bag. The night urinary catheter bag would be changed monthly unless specific [specified] differently by a physician. 10. Review of the provider's 4/13/20 Hand Hygiene policy revealed that hand hygiene was to be completed by the staff before assisting a resident to eat. 11. Review of the provider's 1/22/18 Assisted Dining Program Curriculum revealed that the staff were to perform hand hygiene before and after each resident contact and between different residents when feeding.