STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435035	A. BUILDING ______ B. WING ______	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	**2200 13TH AVE BELLE FOURCHE, SD 57717**

(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 10/15/24 through 10/17/24. Rolling Hills Healthcare was found not in compliance with the following requirements: F550, F584, F610, F657, F658, F686, F804, and F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/15/24 through 10/17/24. The areas surveyed were resident abuse and neglect and the quality of resident care and treatment. Rolling Hills Healthcare was found not in compliance with the following requirement: F804.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550	Corrective Action Resident 6 was given a bath on 10/22/2024 and refused a bath on 11/1/2024. Resident 3 was given a bath on 10/23/2024, and 10/30/2024. Resident 26 was given a bath on 10/18/2024, 10/25/2024, 10/28/2024 and 10/31/2024. Resident 18 had clothing changed, face and mouth washed on 10/15/2024 at 410pm as noted in survey findings. Residents 32 and 26- no corrective action could be taken for staff standing while assisting with eating in the past. Residents 29 and 5 no corrective action could be taken for skin exposure in the past. Activities and Social services will assess resident 5 and 29 clothing and remove shirts that are too small and offer shirts that are fitting from facility clothing or purchase new ones. Identification of Others All residents (resident) are at risk for dignity related to bathing. All residents' bathing was reviewed to ensure all residents had received a bath on or before 11/1/2024.	11/9/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: THarwood
TITLE: Licensed Nursing Home Administrator
(X6) DATE: 11/9/2024

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 550 Continued From page 1

must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on interview, observation, record review, and policy review, the provider failed to ensure:
*Residents maintained a sense of dignity by providing assistance to bathe once per week for 3 of 6 sampled residents (3, 6, and 26).
*One of one sampled resident (18) had received staff assistance to change her clothes following one of two observed meal services in the Bistro dining room.
*Staff had not stood over 2 of 2 observed residents (26 and 32) to assist them during 2 of 2 observed meal services in the Bistro and main dining rooms.
*Two of two observed residents (5 and 29) were dressed in a dignified manner during one of one observed meal service in the main dining room.

F 550

All residents are at risk for dignity related to soiled clothing after meal service. All residents will be visualized at least one time after meal before 11/9/2024 to ensure soiled clothing is changed. All residents are at risk for dignity related to assisted dining. All residents requiring assistance will be reviewed before 11/9/2024 to ensure staff are providing assistance in a dignified manner. All residents are at risk for dignity related to properly fitted clothing. All residents will be reviewed by 11/9/2027 to ensure resident has properly fitting clothing that covers stomachs.

Systemic Changes
Verbal education was given to bath aides by LNHA on 10/17/2024 of their role and responsibility to follow the bath schedule, complete all baths on the schedule, document all baths in electronic medical record, and notify nurse for residents refusing baths. Bath aides were given education by senior staff/previous bath aides on time management to ensure all resident baths are given as scheduled. Bath aide roles were modified and responsibility to assist with meals was removed on 10/21/2024 to allow more time dedicated to giving baths.
IDT (Interdisciplinary Team) began

reviewing baths daily on 10/29/2024 to ensure and make corrections of any missed baths, including residents who refused, to ensure adequate bathing is provided. LNHA (Licensed Nursing Home Administrator), DON (Director of Nursing) and bath aides did review, revised, and developed a new bathing list to start on 10/28/2024.

Stools were purchased on 10/30/2024 and delivered on 11/5/24 for aides to use to sit at equal height of residents requiring assisted dining.

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F 550	Continued From page 2 Findings include: 1. Interview and observation on 10/15/24 at 4:39 p.m. of resident 6 with certified nursing assistant (CNA) O in her room revealed: *She was lying in her bed, awake. -Her hair was shoulder-length and appeared to be greasy. *She stated she would like to receive one bath per week but did not always receive one. Review of resident 6's medical record revealed: *Her care plan indicated she preferred one bath per week and needed extensive assistance of one staff member to complete the bath. *Her bathing record indicated the following: -In August 2024 she received a bath on the 2nd, 16th, and 23rd. --In August 2024 she refused a bath on the 9th and 27th. -In September 2024 she received a bath on the 27th. -In October 2024 she received a bath on the 16th. Review of resident 3's medical record revealed: *Her care plan indicated she was to receive a bath once per week and she required the total assistance of a staff member to complete the bath. *Her bathing record indicated the following: -In August 2024 she received a bath on the 26th and the 28th. -In September 2024 she received a bath on the 4th, 13th, and 18th. -In October 2024 she received a bath on the 2nd and the 16th. Review of resident 26's medical record revealed: *His care plan indicated he required the total	F 550	Education: All education will be given to designated staff on or before 11/9/2024. Those who have not received the education prior to 11/9/2024 will be given education prior to working next shift. IDT and Medical director did review and approve Bath, Shower/Tub Policy, Bathing Schedule Outline Jan 2024 (identifying scheduling baths), Dignity Policy and Dining Experience, on 11/8/2024. Nursing management, charge nurses and bath aides will be given education on the Bath, Shower/Tub Policy and Bathing Schedule Outline regarding dignity and the purpose to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Education will include: 1. ensuring baths/showers are documented on the day it was performed by the aide who performed the task. 2. Documenting resident refusals and notifying the nurse or admin of the refusal. All staff will receive education on Dignity Policy that includes: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Education includes ensuring residents receive weekly bathing, ensuring resident's soiled clothing is changed to protect dignity, ensuring soiled linens are removed from resident rooms, ensuring resident clothing covers stomachs, verbally and physically assisting residents with their clothing, notifying a member of IDT if resident clothing is not fitting, to ensure dignity is not compromised. All staff will receive education on Dining Experience. The dining experience will be person-centered with the purpose of enhancing quality of life and being supportive of resident needs during dining.	

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F 550	Continued From page 3 assistance of one staff member to complete a bath. *His bathing record indicated: -In August 2024 he received a bath on the 9th, 16th, and 19th. -In September 2024 he received a bath on the 16th, and 23rd. -In October 2024 he received a bath on the 4th. Interview on 10/17/24 at 10:09 a.m. with CNA N regarding resident bathing revealed: *She assisted residents with their bathing. *There was a bath schedule that listed when a resident was to receive a bath. -Most residents took a bath once a week. *Residents' bathing documentation was completed in their electronic medical record (EMR). -She confirmed no documentation of bathing was completed on paper. *When a resident refused a bath, she would notify a nurse. Interview on 10/17/24 at 11:05 a.m. with CNA I regarding resident's bathing revealed: *Residents received one or two baths per week. *When a resident refused a bath, she would notify a nurse and ask the resident later if they wanted to take a bath. *Residents' bathing documentation was completed in their EMR. Review of residents' bathing documentation and interview on 10/17/24 at 2:45 p.m. with director of nursing (DON) B and administrator A revealed: *Administrator A reviewed residents 3, 6, and 26 bathing documentation and confirmed the baths listed above for each resident was what had been recorded in their EMR.	F 550	Education will include ensuring staff will sit next to a person when assisting them with eating and assisted with dining for combative residents. Monitoring All monitoring will be done three times weekly until a lessor frequency is determined by the IDT/QAPI committee. DON or Designee will monitor resident baths/showers to ensure residents are bathed as scheduled and documentation has been completed for all baths given or refused. DON or Designee will monitor resident clothing after meals to ensure soiled clothing is changed and soiled clothing protectors are not left in resident rooms, resident clothing fits, staff are assisting if clothing does not cover trunk of body, and staff are aware who to inform if resident clothing is not fitting to promote dignity. DON or Designee will monitor staff during assisted dining to ensure staff are not standing over a resident while providing assistance.	

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*The resident bath schedule was determined by their preferences identified during their admission process.
-Those preferences "can change weekly".
*Each resident had a staff member "advocate" that reviewed:
-That resident's appearance.
-Their bathing documentation.
*Visited with the resident at least one time each week and asked them if they had any concerns.
-When a resident had a concern, their advocate would assist them in filling out a grievance form.
*Documentation of a resident's bath was to be completed in their EMR.
-They previously documented residents' baths on a paper form, this process was no longer be used.

Review of the provider's February 2018 Bath, Shower/Tub policy revealed:
* "The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin."
*"Documentation
-1. The date and time the shower/tub bath was performed.
-2. The name and title of the individual(s) who assisted the resident with the shower/tub bath."
-"5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken.
-6. The signature and title of the person recording the data."
*"Reporting
-1. Notify the supervisor if the resident refuses the shower/tub bath."
-The policy did not indicate how often a resident would receive a bath or shower.

2. Observation on 10/15/24 at 3:25 p.m. during

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initial tour of resident 18 in her room revealed:
*She was lying in her bed with the head of the bed elevated.
*A clothing protector was soiled and lying on the floor.
*There was no food present at her bedside.
*Her shirt was stained and soiled with food.
*Her lips had dried food on them.
*Her teeth had a layer of food residue on them.
*Unknown CNA entered her room in response to her call light and did not address her appearance or clothing protector on the floor.

Observation on 10/15/24 at 4:10 p.m. of resident 18 in her room revealed:
*Unknown CNAs gowned and entered her room.
-She changed her clothing.
-She washed her face.
-She cleaned her mouth.
3. Observation on 10/15/24 at 12:10 p.m. during the noon meal service in the main dining room revealed:
*Resident 32 was sitting in a wheelchair at a table and was not attempting to eat her meal independently.
*She was being assisted with her meal by dietary aide (DA) Q.
-DA Q stood next to the resident and spooned a pudding-like dessert into the resident's mouth.
-She had not sat down next to the resident when she provided that assistance.
-She left the dining room shortly following that observation.

4. Observation on 10/16/24 at 8:30 a.m. in the Bistro dining room revealed:
*Resident 26 was sitting in a wheelchair at a bedside table with a bowl with eggs, a plate with

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toast, and cups of liquids with straws in them, were placed in front of him.
-Unlicensed medication aide/certified nurse aide (MA/CNA) H assisted the resident with eating his eggs while standing rather than sitting down next to the resident.
-MA/CNA H walked away while resident 26 started eating his toast independently.
-Resident 26 attempted to take a drink from a straw. MA/CNA H returned and stood in front of resident 26 and moved the straw to the resident's mouth. She then moved to his left and continued to stand while assisting him with his meal rather than sitting down next to the resident.
-MA/CNA H walked away to talk to another staff member and assisted another resident out of the dining room.
*CNA G stood up from assisting a different resident and walked over to an unidentified resident, stood to his left, and assisted him with his oatmeal rather than sitting down next to the resident.

Interview on 10/16/24 at 8:47 a.m. with MA/CNA H regarding the above observation revealed:
*She stated she had to stand rather than sit next to resident 26 because a chair and the bedside table were not at an equal height.
*If she had sat, she was at "fist level" if he had swung at her.

Interview on 10/16/24 at 9:00 a.m. with CNA G regarding the above observation of an unidentified resident revealed she:
*Stated, "We do what we can."
*Stated sometimes he was able to. On the days he cannot feed himself they would have assisted him and that would have included them standing rather than sitting down next to him.

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Interview on 10/17/24 at 4:26 p.m. with administrator A regarding the above observations revealed:
*She had been monitoring the staff for standing during mealtimes rather than sitting down next to the residents.
*Staff had received disciplinary action for standing during mealtimes rather than sitting down next to the residents.
*Agreed there had been a concern with staff standing during mealtimes rather than sitting down next to the residents.

Review of the provider's 2019 The Dining Experience Policy revealed:
*Policy:
"The dining experience will be person-centered with the purpose of enhancing each individual's quality of life and being supportive of each individual's needs during dining. Individuals will be provided with nourishing, palatable, attractive meals that meet daily nutritional, and/or special dietary needs and food preferences and are served at a safe and appetizing temperature. Individuals will be provided restorative dining services as needed to maintain or improve eating skills."
-"11. Staff will sit next to a person when assisting them with eating (rather than standing over them)."
5. Observation on 10/16/24 at 5:30 p.m. during the evening meal service in the main dining room revealed:
*Resident 29 entered the dining room and then positioned himself in his wheelchair at an angle along the side of the dining table.
*He wore a flannel shirt over the top of his t-shirt.
-The center button of the flannel shirt was

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F 550	Continued From page 8 buttoned. *His bare stomach was exposed beneath the bottom edge of those shirts. Continued observation revealed: *Resident 5 entered the dining room and positioned himself in front of a dining table. *His bare stomach was exposed beneath the bottom edge of his green t-shirt. -He was unable to pull his shirt over his stomach to cover it because it appeared too small. Interview on 10/17/24 at 4:50 p.m. with administrator A regarding the above main dining room observations revealed residents 5 and 29 should have been verbally and or physically assisted with their clothing by staff to ensure their dignity had not been compromised. Review of the provider's February 2021 revised Dignity policy revealed: "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem."	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584	Corrective Action Burgundy lounge chair was cleaned to remove odor. Carpet stains in common area have been shampooed before 11/8/2024. Resident 18 passed away 10/22/2024. Room was deep cleaned 11/5/2024. Dirt, dust, food particles, betadine swab, wrappers. med cup, cups, utensils, creams, mouth swabs, care items, blankets, paper towels, tissues, and briefs were removed from room. Resident belongings, clothing, gait belt, and TV table were removed. Linens and sling were removed from room.	11/9/2024

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F 584	Continued From page 9 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review the provider failed to ensure: *One of three public areas (300 wing) was free of urine odor, a chair did not have a urine odor, and carpet stains. *Two of three sampled residents rooms (12 and 18) were kept in a clean and homelike manner. *Two of three sampled residents rooms (6 and	F 584	Resident 12 passed away 10/28/2024, No action to be taken regarding resident family's concerns of odor, cleanliness, sheets, and previous grievances. Resident 12's room was deep cleaned, carpet shampooed on 11/1/24. Resident 6's room was deep cleaned before 11/8/24 to remove odor smells. Identification of Others All cloth chairs in the common area were inspected. Chairs that had odors were shampooed, and clean covers applied. All other chairs had clean covers applied by 11/8/24. All of the common area was inspected for causes of odors and cleaned. All resident rooms were inspected for odors. Resident rooms with odors were deep cleaned and causes of odors were removed or laundered before 11/8/2024. Laundry inspected sheets and discarded sheets with holes before 11/8/2024. Systemic Changes Facility is in a final process for a remodel for the public areas associated with findings. Remodel includes removing carpeting from common areas and purchasing new r ecliners for common area. Remodel is expected to begin beginning or middle of December 2024. Resident advocate rounds were updated to include checking for odors, putting items in rooms away, removing dishes and used supplies from resident rooms. Housekeeping daily room cleaning was updated to include sweeping under beds, checking for and removing odors, removing items from floors and tables, removing garbage, used paper products, dishes, dirty linens, hanging up gait belts and slings, dusting in rooms, cleaning carpet stains, wet mopping floors to remove dust,	

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18) were free of urine odor.

1. Observation on 10/15/24 from 9:30 a.m. through 9:45 a.m. of the public area located in the 300 wing revealed:
*Lounge chairs in the common area that were made of cloth fabric.
-A burgundy lounge chair smelled of urine.
*A strong odor of urine was present throughout the area.
*Brown stains were on the carpet in multiple locations.

2. Random observations on 10/15/24 from 12:45 a.m. through 4:34 p.m. of resident 18's room revealed:
*There was a strong odor of urine in resident's 18's room.
*A med cup with a dark yellow substance and an empty water glass was on the over-the-bed table.
*Multiple creams, mouth swabs, and care items were on the top of the bedside table.
*A pile of blankets and clothing was on the recliner.
*An open closet door with resident belongings on the floor of the closet.
*A gait belt was lying on the bare mattress of the bed.
*A television (TV) table with two paper towels covering the TV table.
-There was a butter knife and a soiled plastic cup cover on those paper towels.
*Present on the floor were:
-Black socks in front of the recliner.
-A soiled clothing protector on the floor beside the bed.
-An open package of incontinent briefs in the hallway just inside the door to the room, visible to anyone walking by.

F 584

and making beds and cleaning mattresses on beds that have had linens soiled.
Housekeeping will wash all resident mattresses on their designated bath day (or first bath).
Housekeeping manager will complete rounds weekly to look for carpet stains and odors in common areas and inspect recliners for odors and cleaning.
Housekeeping supplied cleaning products in dirty utility rooms that contain carpet cleaner, all purpose cleaner, toilet cleaner and toilet brush.

Education:
All education will be given to designated staff on or before 11/9/2024. Those who have not received the education prior to 11/9/2024 will be given education prior to working next shift.
All housekeeping and laundry staff will be educated about changes in duties and ensuring resident rooms and common areas are clean, safe, and comfortable to comply with resident rights for a homelike environment, education to ensure services are maintaining a sanitary, orderly and comfortable interior, providing clean bed and bath linens in good condition.

Education to all staff for their participation in ensuring resident rooms and common areas are clean, safe and comfortable to comply with resident rights for a homelike environment, education on safety risks, resident property protection, ensuring residents can use their personal belongings, receive care and services safely, ensuring the facility layout maximizes independence and does not pose a safety risk. Education ensures services are maintaining a sanitary, orderly and comfortable interior, providing clean bed and bath linens in good condition, making beds with fitted sheet and unfolded top sheets and making the bed look nice

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	435035	A. BUILDING _____ B. WING _____	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE BELLE FOURCHE, SD 57717

(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
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-Multiple wadded up tissues near the bed.
-Dirt, dust, and food particles under the bed.

Observation on 10/16/24 at 4:14 p.m. and on 10/17/24 at 9:30 a.m. of resident 18's room revealed:
*The same observed items as 10/15/24.
*Additional items that were observed included:
*Present on the floor were:
-A open, used, Betadine swab beside the head of the bed.
-The wrapper for 4 x 4 gauze drain sponge on the floor in front of the bedside table.
*Sit to stand sling was lying on the bare mattress of the bed.

Interview on 10/16/24 at 4:44 p.m. with unlicensed medication aide/certified nurse aide (UMA/CNA) V regarding resident 18's room revealed:
* When asked about the condition of the room he picked up some of the objects that were on the TV table and over the bed table.
*Another CNA entered the room and made the bed.

Interview on 10/17/24 at 4:32 p.m. with administrator A regarding resident 18's room revealed she stated, "I'll have to check on it."

Record review on 10/17/24 at 11:30 related to resident 18 revealed:
*Her diagnoses included multiple communicable diseases that included hepatitis C and multi-drug resistant organisms.
*She had a stroke affecting her dominant right side.
-Her right hand was contracted.
*She had an impaired immune system related to

Provider's Plan of Correction (F 584, continued):

and welcoming, ensuring residents have private closet space, and lighting is comfortable in all areas. Education to ensure odors are removed from rooms, gait belts, blankets and slings are put away, linens are removed from rooms. rooms are free from dirt, dust, food particles, used care supplies, dishes, garbage, bedding is free from holes, beds are made, personal care items are put in areas that protect dignity. Education on all staff's responsibility to clean odors when they are found, carpet cleaner, all purpose cleaner, toilet cleaner and brush supplied in dirty utility rooms.

Monitoring
All monitoring will be done three times weekly until a lessor frequency is determined by the IDT/QAPI committee. LNHA or designee will complete monitoring of 300 hall common area and resident rooms to ensure areas odor free, carpet stains have been cleaned, rooms are free fr om dirt, dust, food particles, used care supplies, dishes, and garbage. To ensure blankets, gait belts and slings are put away, bedding is free from holes, beds are made, personal care items are put in areas that protect dignity.

Housekeeping manger or designee will monitor to ensure common areas and recliners are odor free, monitor resident rooms to ensure they are odor and stain f ree, housekeeping is sweeping under beds, checking for and removing odors, removing items from floors and tables, removing garbage, used paper products, dishes, dirty linens, hanging up gait belts and slings, dusting in rooms, cleaning carpet stains, wet mopping floors to remove dust, and making beds.

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her chronic diseases.
*Her care plan included she was at a high risk for infection.
-She was on contact and enhanced barrier precautions (use of personal protective equipment such as gloves, gown, and/or eyewear).
*She had a suprapubic catheter (tube surgically placed to drain urine) and required assistance from a staff member for suprapubic catheter care.

3. Interview on 10/15/24 at 11:37 a.m. with resident 12's daughter revealed:
*She felt that the building and grounds were not cared for.
*She stated that the facility smelled of urine and was "dreary".
*She stated that this was the fourth room that her mother had been in, since her admission on 8/16/23, and this room was cleaner than the previous rooms.
*She reported that prior to the family having purchased sheets for her mother's bed, the bottom sheets often had holes in them and there was no top sheet on the bed.
*She had witnessed that often the residents' beds were not made.
*She stated that she had filed a grievance previously, but she did not feel that a change was made.

4. Observation on 10/17/24 at 11:45 a.m. of resident 6's room revealed a distinct odor of urine.

5. Interview on 10/17/24 at 2:45 p.m. with director of nursing B and administrator A revealed:
*Each resident had a staff member "advocate" that reviewed:

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F 584	Continued From page 13 -That resident's appearance. -Cleanliness of their room and any non-cleanable surfaces. *Visited with the resident at least one time each week and asked them if they had any concerns. -When a resident had a concern, their advocate would assist them in filling out a grievance form. 6. Interview on 10/17/24 at 2:35 p.m. with housekeeper U revealed: *She cleaned the hallway floors, both dining rooms and the residents' rooms daily. *Cleaning of the residents' rooms included she: -Removed trash bags from the trash cans and placed a clean trash bag in the trash can. -Swept the floors with a dry mop. -Cleaned the bathroom mirrors, cleaned the sink, cleaned and flushed the toilet. -Wiped the bedside tables and around the television stands. -Wiped all the handles in the residents' room. *She stated she would only dust if the residents were not in the room. *She stated she would get notified to clean up spills that happened during the day.	F 584		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610	Corrective Action Administrator reported incident including investigation for resident 12 fracture and submitted Facility Reported Incident to Department of Health on 10/22/2024. Administrator shared the investigation findings with the DON that was completed at the time of the incident. Identification of Others Facility Administrator reviewed all current resident injuries to ensure investigation is complete, and unknown injuries are reported to Department of Health before 11/9/2024.	11/9/2024

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F 610	Continued From page 14 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review the provider failed to investigate one of one injury of unknown origin for one of one sampled resident (12) findings include: 1. Interview with resident 12's daughter on 10/15/24 at 11:37 a.m. revealed: *Resident 12 was sent to the emergency department on 9/24/24 due to an unresponsive episode. *Upon return to the facility, staff transferred resident 12 with a sit-to-stand lift. - One of resident 12's daughters noted her left leg was unstable and informed the staff member that was performing the transfer. *On 9/26/24 family of resident 12 "demanded" X-ray of resident 12's left leg. Review of resident 12's electronic medical record (EMR) revealed: *A 9/25/24 nurses note documented: "c/o [complaints of] pain when moving the leg out or when the area above the knee is touched. No edema and no known injury". *On 9/26/24 she was seen by a Certified Nurse Practitioner. - On 9/26/24 an X-ray was ordered and an "acute, displaced oblique fracture through the distal femoral diaphysis" was diagnosed.	F 610	Systemic Changes IDT and Medical director did review and approve Abuse, Neglect, Exploitation or Misappropriation, Reporting and Investigating Policy on 11/8/2024. Education: All education will be given to designated staff on or before 11/9/2024. Those who have not received the education prior to 11/9/2024 will be given education prior to working next shift. All staff will be given education on facility Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy to ensure all reports of resident abuse (including injuries of unknown origin), neglect, exploitation or theft/misappropriation of resident property are investigated and reported to Administrator or designee to report to local, state and federal agencies (as required by current regulation) and thoroughly investigated by facility management. Education includes that the Administrator has facility investigation evidence and documentation to support that all alleged violations are thoroughly investigated, all investigations will prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in process. Education to ensure all results of all investigations are reported to the Administrator or designee and other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	

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F 610	Continued From page 15 Interview with director of nursing (DON) B on 10/16/24 at 3:45 p.m. regarding resident 12's fracture revealed: *On 9/25/24 she was notified of resident 12's left leg pain early in the a.m. * On 9/25/24 at 8:52 a.m. she notified the primary care provider of resident 12's left leg pain and her family was aware. -She received an order for an X-ray. -Family was present and aware of the X-ray order. *She stated that there was no known cause of resident 12's fracture and she had a history of pathological fractures. *She confirmed that she had not reached out to the emergency department to inquire about resident 12's pain or injury during her 9/24/24 visit. *She confirmed that she had not reported resident 12's fracture to any outside agency such as the South Dakota Department of Health (SD DOH). *She confirmed there was no documentation to support an investigation was completed. Review of the provider's September 2022 Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy revealed "All reports of resident abuse (including injuries of unknown origin), neglect, exploitation or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported."	F 610	Monitoring All monitoring will be done three times weekly until a lessor frequency is determined by the IDT/QAPI committee. LNHA or designee will complete monitoring to ensure all resident injuries are thoroughly investigated to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in process, investigation is documented results of all investigations are reported to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action has been taken.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657	Corrective Action Resident 18 passed away 10/22/2024. Corrective action to care plan could not be taken.	11/9/2024

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F 657	Continued From page 16 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure 5 of 8 sampled residents (6, 18, 26, 29, and 46) had their care plans followed, updated, and revised promptly to reflect their current status and care needs. Findings include: 1. Observation on 10/15/24 at 3:25 p.m., during the initial tour, of an unknown certified nursing	F 657	Resident 29s left footrest with Velcro strap was removed at custom wheelchair appointment at VA on 11/5/2024, a new foot pedal was provided without Velcro strap and has a footbox to keep foot from sliding off. Resident 46s care plan was updated to include resident relies on staff for interventions to prevent falls and interventions on diet care plan stating to educate resident was revised to reflect resident's nutrient restrictions and risks. Resident 26's order for seat belt release was discontinued on 10/17/2024. The care plan was updated to reflect custom wheelchair has a seatbelt that is not used. The custom wheelchair company, Lifescape, was contacted and request to remove seatbelt from wheelchair at next maintenance visit. Seatbelt has been secured under wheelchair seat. Resident 6's care plan was updated to reflect bed height. Identification of Others All residents' care plans are reviewed and updated to reflect status and care needs and if residents depend on staff for care plan and interventions. Systemic Changes IDT and Medical director did review and approve Care Plans, Comprehensive Person-Centered policy on 11/8/2024. Education: All education will be given to designated staff on or before 11/9/2024. Those who have not received the education prior to 11/9/2024 will be given education prior to working next shift. Education to ensure interventions are appropriate based on resident.	

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F 657 Continued From page 17

assistant (CNA) revealed:
*That CNA responded to resident 18's call light and asked resident 18 if she needed to put a gown on. -Resident 18 nodded no and the CNA exited the room.

Observation on 10/15/24 at 4:10 p.m. of the same CNA above revealed she put a gown and gloves on prior to entering Resident 18's room.

Review of resident 18's 10/16/24 care plan revealed:
*A focus area indicated she had a compromised immune system.
-An intervention for this focus area directed: "Staff will follow contact precautions with providing cares to resident per M.D. orders".
*A focus area that indicated she had an autoimmune disease and the potential for complications.
-An intervention for this focus area directed: "Enhanced Barrier Precautions (EBP) for high contact care activities PMH [past medical history] of ESBL [a bacterial infection resistant to some antibiotics] in urine".

Interview on 10/17/24 at 9:55 a.m. with CNA I regarding precautions for resident 18 revealed she did not know the name of the precautions but stated she wore a gown when she provided direct care for resident 18.

Interview on 10/17/24 at 10:04 a.m. with registered nurse (RN) J regarding resident 18 was on revealed she stated that resident 18 was on contact precautions.

Interview on 10/17/24 at 10:13 with director of nursing (DON) B regarding the type of

F 657 Education provided to all IDT members who actively participate in care planning and revisions to ensure care plans are reviewed and revised after each assessment, including both comprehensive and quarterly review assessments, ensuring care plans are person centered, consistent with resident rights to participate in the development and implementation of care plans or explanation if participation is not practicable, is derived from information of the comprehensive assessment, consistent with resident right to receive the services and/or items included in the care plan, the care plan includes measurable objectives and timeframes, describes the services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, chosen after consideration between the resident's problem areas, causes, and relevant clinical decision making, interventions address underlying source of problem areas, not just symptoms or triggers, care plans are revised as information and conditions change. Education to update care plans where there has been a significant change, when desired outcome is not met, when resident has been readmitted to the facility from a hospital stay, and at least quarterly in conjunction with the required quarterly MDS assessments. Education provided to all staff to update IDT of changes in resident care status and care needs, changes to interventions, any care planned interventions that are not in place or meeting the resident needs.

Monitoring
All monitoring will be done three times weekly until a lessor frequency is determined by the IDT/QAPI committee.

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F 657	Continued From page 18 precautions that resident 18 was on revealed: *She confirmed that resident 18 was on EBP. *She confirmed that resident 18 had previously been on Contact Precautions. -The contact precautions were recently lifted due to resident 18's "CD4 count [test that measures the number of white blood cells in the blood] being within normal limits." 2. Observation on 10/17/24 at 9:30 a.m. revealed resident 18's AFO (brace that stabilizes and controls the range of motion of the foot and ankle) revealed: *Brace was lying on the floor of her closet. Review of resident 18's 10/16/24 care plan revealed a focus area that indicated "I [resident 18] have a right lower extremity AFO that I am to wear for all ADL [activities of daily living] transfers and ambulation as tolerated. Review of resident 18's 8/27/24 Physical Therapy PT Evaluation & Plan of Treatment revealed: *She was dependent on staff assistance with all transfers. *Ambulation was marked as "Not applicable". Interview on 10/17/24 at 9:55 a.m. with CNA I regarding the use of the AFO for transfers and ambulation revealed: *She had not used the AFO on resident 18 "Since I started working here." -CNA clarified that she had been employed there for greater than one year. *Resident 18 transfered solely with a sit-to-stand lift (mechanical lift used to transfer from a seated position to standing). *Resident 18 does not ambulate.	F 657	LNHA or designee will monitor to ensure resident care plans are reviewed, revised as information and conditions change, with significant changes, when readmitted, at least quarterly and when desired outcome has not been met. Care plans are consistent with assessments, person centered, has measurable objectives and timeframes, describes the services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, interventions address underlying source, not just symptoms or triggers, residents receive services or items included in the care plan that are chosen from resident problem areas, causes and clinical decision making.	

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Interview on 10/17/24 at 10:04 a.m. with RN J regarding the use of resident 18's AFO for transfers and ambulation revealed:
*She confirmed that the AFO was discontinued by the physician orders.
*She confirmed that resident 18 was transfered solely with the use of a sit-to-stand lift.
*She confirmed that resident 18 did not ambulate.

Interview on 10/17/24 at 10:30 a.m. with DON B regarding the use of the AFO for transfers and ambulation revealed she did not "believe" the AFO was still in use for resident 18.

3. Observation and interview on 10/15/24 at 11:23 a.m. with resident 29 revealed:
*He was seated in a wheelchair.
-His left foot was strapped to the wheelchair pedal with a Velcro strap.
-His left arm was strapped to an arm support on the wheelchair with a Velcro strap.
*He stated he was paralyzed on the left side and the Velcro strap on his left foot was to keep it from sliding off the wheelchair pedal.
*He stated he was unable to remove either Velcro straps.

Review of resident 29's care plan revealed:
*He used a left arm tray on his wheelchair that had a Velcro strap to hold his hand in place on it.
*The use of the left foot Velcro strap was not reflected in his care plan.

Interview on 10/17/24 at 10:09 a.m. with CNA N regarding resident 29 revealed a staff member assisted resident 29 with the placement of the Velcro straps to his left foot and left hand.

Interview on 10/17/24 at 11:12 a.m. with CNA I

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regarding resident 29's use of Velcro straps revealed:
*He used them to stabilize his hand and foot.
*He asked staff to attach the Velcro straps to his hand and foot each day.

4. Observation on 10/15/24 at 3:43 p.m. of resident 46 being transferred from his wheelchair to his bed by CNA O and an unknown CNA revealed:
*A full-body mechanical lift (a device with a sling used for transfers) was used.
*Resident 46 did not talk or respond to the CNAs.

Review of resident 46's medical record revealed:
*His 7/17/24 Brief Interview for Mental Status (BIMS) score was a 1, which indicated he had severe cognitive impairment.
*His diagnoses included: Alzheimer's disease and dementia with psychotic disturbance and agitation.
*His 10/16/24 care plan included:
-He used a wheelchair and the assistance of one staff for locomotion.
-He required the use of a full-body mechanical lift for transfers.
-A 7/17/24 focus area indicated he was at risk for falls and injuries related to his cognitive impairment.
--The interventions for this focus area included: encourage use of adaptive equipment, if necessary; encourage to request assistance whenever needed; and "Instruct client to wear well-fitting slippers/shoes with nonslip soles and low heels when ambulating."
-A 7/17/24 focus area indicated his diet was "EASY TO CHEW".
--An intervention for this focus area included "Educate patient on nutrient restriction and on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 21 risks of not following diet restrictions." 5. Observation on 10/15/24 at 3:23 p.m. of resident 26 revealed: *He was in the lobby area watching television. *He was seated in a wheelchair with an unlatched seat belt attached to it. Review of resident 26's medical record revealed: *His BIMS assessment was not able to be completed. -A staff assessment of his cognition on 8/13/24 indicated his cognition was moderately impaired. *His diagnoses included: dependence on wheelchair, convulsions, epilepsy, and hemiplegia (paralysis) affecting his left side. *A 10/10/22 physician order for "Wheelchair Seatbelt: Release for 20 mins [minutes] every 2 hours while seatbelt is in use." *His 10/16/24 care plan did not include any information regarding the use of a seat belt on his wheelchair. Interview on 10/16/24 at 6:35 p.m. with CNA S regarding resident 26's use of a seat belt revealed: *He used a seat belt when seated in his wheelchair. -He would often remove it himself. -A staff member would reattach it around his waist when he removed it. Interview on 10/17/24 at 7:59 a.m. with administrator A regarding resident 26's seat belt use revealed: *His wheelchair was custom fit to his needs. -There was a non-removable seatbelt attached to his wheelchair. -He was able to unlatch the seat belt from around	F 657		

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himself.
-He had stopped using the seat belt when in his wheelchair.
-Some staff members had still placed and latched it around him.

Interview on 10/17/24 at 11:04 a.m. with CNA I regarding resident 26's use of a seat belt when seated in his wheelchair revealed he only wore the seat belt when going for a bus ride.

Interview on 10/17/24 at 11:42 a.m. with DON B regarding resident 26's seatbelt use revealed:
*He removed the seat belt as soon as it was placed around him.
-She was not aware if he used it when on a bus ride.

6. Observation on 10/17/24 at 10:27 a.m. of resident 6 in her room revealed a strip of blue tape, approximately 2 inches by 4 inches across the top inside edge of her headboard.

Review of resident 6's 10/16/24 care plan revealed:
*There was a focus area that she was at risk for falls.
-The intervention for this focus area included "BED HEIGHT: When in Standard position [the bed was] to be 35.5 inches per Blue Tape visual marking on wall."

Interview on 10/17/24 at 11:15 a.m. with CNA I regarding the height a resident's bed should be revealed:
-When there was a blue strip of tape on the wall, that is where a resident's bed height should be.
-She confirmed resident 6's bed should have a strip of blue tape on the wall and the headboard.

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--There was no blue tape on the wall.
-She would "just eyeball it" to ensure it was at the right height.

Interview on 10/17/24 at 11:22 a.m. with DON B regarding the height of residents' beds revealed:
*There was a piece of blue tape on the wall and on the head of the bed that were to match up to ensure the proper height of the bed for that resident.
*Everyone was responsible for ensuring the tape was in place.
-No one was assigned to complete a routine check of tape to ensure it was in place.
-Her expectation was for the tape to be replaced when it was missing.

7. Interview on 10/17/24 at 11:32 a.m. with DON B regarding residents care plans revealed:
*The interdisciplinary team (IDT), including the dietary manager, Minimum Data Set (MDS) nurse, social service staff member, director of nursing, and the administrator would meet to discuss any changes to the care a resident may require.
*The MDS Nurse would update the care plan or assign another IDT member to update it.
*Individual resident care plans were to be updated as needed, including resolving issues in the care plan when needed.

8. Review of the provider's March 2022 Care Plans, Comprehensive Person-Centered policy revealed:
*"A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident."

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*"The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident."
*"The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment."
*"Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to:"
-"receive the services and/or items included in the plan of care;"
*"The comprehensive, person-centered care plan:"
-"Includes measurable objectives and timeframes;"
-"Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ..."
*"Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making."
*"When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers."
*"Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change."
*"The interdisciplinary team reviews and updates the care plan:
-a. when there has been a significant change in the resident's condition;
-b. when the desired outcome is not met;

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F 657	Continued From page 25 -c. when the resident has been readmitted to the facility from a hospital stay; and -d. at least quarterly, in conjunction with the required quarterly MDS assessment."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure: *Two of two residents (12 and 35) who had an oxygen concentrator in their room and did not have a physicians order for oxygen administration. *One of one sampled resident (18) used a physician's ordered therapeutic boots. *One of one sampled resident (6) meal documentation was accurate for one of one meal by one of one certified nursing assistant (CNA) (I). *One of one sampled resident (29) had been assessed for restraint use of Velcro straps holding his foot and arm in a secure position. *One of one sampled resident (25) who self-administered medication had his self-administration assessment completed accurately. 1. Observation on 10/15/24 at 11:24 a.m. of resident 12's room revealed: *An oxygen concentrator was at her bedside. *Oxygen tubing was attached to the concentrator	F 658	Corrective Action Resident 12's concentrator was removed as resident was not actively using oxygen prior. Resident 12 passed away 10/28/2024. Resident 35's oxygen use was verified that she does not use oxygen, the concentrator in the room was resident 12's and has been removed. Resident 18 passed away 10/22/2024. Resident 18's order could not be clarified, and care could not be updated. Resident 6's inaccurate meal documentation was struck out and accurately documented on 11/3/24. Resident 29 received an assessment for use of Velcro strap use for arm as a restraint on 11/9/2024 the strap for the left foot has been removed and a new foot rest has been provided. Resident 25's self-administration of medication was completed on 11/1/24 to i nclude type of medication resident is able to self-administer. Identification of Others All residents who have oxygen concentrators in their rooms were reviewed to ensure there is an active oxygen administration order from physician, and care plan includes oxygen use. All residents were reviewed for use of therapeutic boots. Residents identified with therapeutic boots were reviewed to ensure physician orders are entered, clarified and care plan updated to reflect order and use.	11/9/2024

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F 658	Continued From page 26 and was draped over the top of it. Interview on 10/15/24 at 11:37 a.m. with resident 12's daughter regarding oxygen use revealed: *The oxygen concentrator had been used as needed by resident 12 since she returned from the emergency department on 9/24/24. -Resident 12 had required oxygen most often in the morning "after sleeping." Review of Resident 12's electronic medical record (EMR) oxygen use revealed: *There was no physician order for the administration of oxygen. *The care plan did not include her use of oxygen. Interview on 10/17/24 at 10:13 a.m. with director of nursing (DON) B regarding resident 12's use of oxygen revealed she: *Confirmed there was no order for oxygen for resident 12. *Was not aware of resident 12's oxygen use. -Stated that the oxygen concentrator in that room was for resident 35. Review of resident 35's EMR use of oxygen revealed no order for oxygen for resident 35. 2. Observation on 10/17/24 at 09:30 a.m. of resident 18's room revealed: *An AFO (brace that stabilizes and controls the range of motion of the foot and ankle) was lying on the floor in the resident's closet. *There were no other braces or boots visualized in the room. Interview on 10/17/24 at 9:55 a.m. with CNA I regarding resident 18's use of brace/boots for her legs at night revealed she:	F 658	All residents who are at risk for weight loss had meal intake documentation reviewed before 11/9/2024 for accuracy based on resident, staff, or dietary interviews. All residents with straps were assessed as a restraint by 11/9/2024. All self-administration of medication assessments were reviewed to ensure the medication is listed on the assessment. CNA I was given documented individual education regarding accurately documenting meal intakes on 11/6/2024. Systemic Changes IDT and Medical director did review and approve Restraints and Resident Assessments, Conformity with Laws and Professional Standards policies on 11/8/2024. Education: All education will be given to designated staff on or before 11/9/2024. Those who have not received the education prior to 11/9/2024 will be given education prior to working next shift. Education to ensure interventions are appropriate based on resident. All licensed nurses will be educated on Restraints and Resident Assessments, Conformity with Laws, and Professional Standards policies to ensure any new oxygen use for residents have an order entered, all self-administration of medication assessments include medication resident is able to self-administer, all orders are clear and accurate for therapeutic boots. Education to ensure discontinuation of oxygen or boot orders have the item removed from the resident's room, and medical equipment includes clarification of placement locations. Education to ensure assessments are documented accurately regarding the resident's care and condition at the time of the assessment. Education to ensure residents are receiving appropriate nutrition at every meal.	

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F 658	Continued From page 27 *Had been employed there for greater than one year. *She had not removed braces from resident 18, in the morning, in the time she had worked there. Interview on 10/17/24 at 10:04 a.m. with registered nurse (RN) J regarding the use of braces or boots at night for resident 18 revealed she: *Did not think resident 18 wore braces or boots at night. *Was only able to locate the AFO in resident 18's room. Interview on 10/17/24 at 10:13 a.m. with DON B regarding resident 18's use of braces or boots at night revealed: *There were two physician orders for therapeutic boots to be worn at night. *She stated that the AFO in resident 18's closet is the same as a Multipodus boot (a device worn on the calf and foot that suspends the heel and holds the ankle at a 90-degree position to remove pressure from the back of the heel and counteract muscle tightness). Interview on 10/17/24 at 10:30 a.m. with Director of Rehab (DOR) L regarding resident 18's use of braces or boots at night revealed: *She confirmed that a Multipodus boot and an AFO brace are not the same. *She confirmed there were two orders in resident 18's physician orders for boots to be worn at night. - A Multipodus boot was ordered for the right foot. - A Thera-boot (leg compression boots to improve circulation) order did not specify a side. *She confirmed with physical therapist K that there was not a Thera-boot or a Multipodus boot	F 658	All staff responsible for documenting meal intake will be educated to notify the nurse if a resident did not eat their meal, offering to assist if not eating, offering alternative options as directed by the nurse, and on Conformity with Laws and Professional Standards policies to ensure accurate documentation of meal proportion and percentages. All staff will be educated on Restraints and Conformity with Laws and Professional Standards policies to ensure understanding resident restraints as any manual method or physical or mechanical devices, material or equipment attached or adjacent to the resident's body that the resident cannot remove easily, restricts from freedom of movement, or restricts normal access to one's body. Education to report to nursing or IDT if resident has confusing or conflicting medical equipment for clarification. Education to ensure when delivering trays, the resident is set up and aware of meal delivery. Education to ensure staff understand the facility operates and provides services in compliance with current federal, state, and local laws, regulations, codes and professional standards of practice, our policies, procedures, and practices are developed written policies and procedures that govern day-to-day operation. MDS nurse will be educated to ensure the IDT conducts timely and appropriate resident assessments and to notify Administrator and IDT member of any questionable or inaccurate assessment that has been completed, including accurate documentation of restraints and self-administration of medications in assessments. Education to nurse managers to ensure resident documentation is reviewed, medical equipment has orders for use, discontinued orders are removed from	

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in resident 18's room.

Review of resident 18's electronic (EMR) use of therapeutic boots at night revealed:
*There were two physician orders for therapeutic boots to be worn at night.
- An order on 7/23/21 instructed to "Ensure wearing thera-boot at night".
--It was scheduled on the treatment administration record (TAR) for every evening shift.
--There was no designation if it was to be worn on the right, left, or both feet.
-An order on 7/23/21 for "Multipodus boot on Right foot at bedtime."
--It was scheduled on the TAR for every night at bedtime.
*Her 10/17/24 care plan did not include the Multipodus boot or the Thera-boot.
3. Observation and interview on 10/15/24 at 4:39 p.m. of CNA O and resident 6 revealed:
*Resident 6 was lying in her bed, awake.
*There was a bedside table next to the bed.
-On this table was a meal tray and a plate of food from lunch that was untouched.
*Resident 6 stated she had a "significant weight loss a while ago".
*CNA O asked resident 6 if she had eaten.
-Resident 6 responded she had "forgotten" that her lunch tray was there.

Review of resident 6's EMR revealed:
*Her diagnoses included: anorexia, depression, moderate protein-calorie malnutrition, diabetes, acute kidney failure, macular degeneration, dizziness, muscle weakness, cognitive communication deficit, and need for assistance with personal care.
*Her weight record indicated she weighed 125.5

F 658

room, and observing resident cares to ensure staff are not confused or conflicted on medical equipment or interventions in place for residents, and nursing is completing documentation of tasks, assessments and orders accurately, and different types of therapeutic boots or other ordered medical equipment, and to review care plans per policy. Education to therapy staff to ensure staff communications regarding medical equipment and care plan changes are clarified and include placement details, as well as changes to prior use of medical equipment.

Monitoring
All monitoring will be done three times weekly until a lessor frequency is determined by the IDT/QAPI committee. DON or designee will monitor to ensure any new oxygen use for residents have an order entered, all self-administration of medication assessments include medication resident is able to self-administer, all orders are clear and accurate for therapeutic boots, discontinuation of oxygen or boot orders have the item removed from the resident's room, medical equipment orders includes placement location, assessments are accurate, residents are receiving appropriate nutrition at every meal or are offered alternatives or supplements, and accurate documentation of meal intake.

DON or designee will monitor to ensure staff are competent on identification and use of restraints, to ensure staff are not confused or conflicted on resident's use of medical equipment. MDS or designee will monitor assessments to ensure accuracy and identify medications and restraints, and notification to IDT member and LNHA is completed for any findings of inaccurate documentation.

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F 658	Continued From page 29 pounds (lbs.) on 4/2/24 and 106 lbs. on 10/1/24. *Her care plan included: -She was at nutritional risk due to her diagnoses. -She preferred to dine in her room. -A staff member was to tell her where her food items were on the plate using the clock method. --She was able to eat independently after a staff member set up her meal. -Staff members were to document the percentage of her meal intake on a tracking form. *Review of resident 6's meal intake tracking form revealed that on 9/15/24 CNA I documented she had eaten 26 to 50 percent (%). Interview on 10/17/24 at 11:05 a.m. with CNA I regarding resident meal intake documentation revealed: *Documentation of meals was completed by whomever picked up the meal tray from a resident's room. *She confirmed that on 10/15/24 she documented that resident 6 had eaten her lunch at 26 to 50% as "that is what she normally eats." -She confirmed she had not observed or picked up resident 6's lunch tray on 10/15/24. Interview on 10/17/24 at 11:25 a.m. with DON B regarding the documentation of resident meal intake revealed: *The person responsible for documenting what a resident had eaten was the person who removed the tray from the resident's room after the meal. -That person was usually a CNA. *She stated, "Everyone has issues with documentation" and she would have expected documentation to be accurate. 4. Observation and interview on 10/15/24 at 11:23	F 658	DOR or designee will monitor therapy staff to ensure the staff communications regarding medical equipment and care plan changes are clarified and include placement details, as well as changes to prior use of medical equipment.	

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F 658	Continued From page 30 a.m. with resident 29 revealed: *He was seated in a wheelchair. -His left foot was strapped to the wheelchair pedal with a Velcro strap. -His left arm was strapped to an arm support on the wheelchair with a Velcro strap. *He stated he was unable to remove either Velcro straps on his own. Review of resident 29's EMR revealed there was no assessment completed to determine if the Velcro straps on his left foot and arm were restraints. Interview on 10/17/24 at 10:09 a.m. with CNA N regarding resident 29 revealed a staff member assisted resident 29 with placement of the Velcro straps to his left foot and left hand. Interview on 10/17/24 at 11:12 a.m. with CNA I regarding resident 29's use of Velcro straps revealed: *He used them to stabilize his hand and foot. *He asked staff to attach the Velcro straps to his hand and foot each day. Interview on 10/17/24 at 11:34 a.m. with director of nursing B regarding assessing resident 29's Velcro straps as a possible restraint revealed: *The straps had not been assessed as a restraint as he had requested the use of them. Review of the provider's April 2017 Use of Restraints policy revealed: *"Policy interpretation and Implementation -1. "Physical Restraints" are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove	F 658		

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F 658	Continued From page 31 easily, which restricts freedom of movement or restricts normal access to one's body." -"6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints." 5. Observation on 10/15/24 at 11:34 a.m. of resident 25 revealed: *He was seated in a recliner in his room. *He was holding a nebulizer mask up to his face. Review of resident 25's medical record revealed: *His diagnoses included chronic obstructive pulmonary disease (COPD), Bronchiectasis (a chronic lung disease that causes the airways of the lungs to widen and become permanently damaged), cognitive communication deficit, and acute respiratory failure with hypoxia. *His 8/2/24 BIMS assessment score was 14, which indicated his cognition was intact. *There was a 3/14/24 physician order for Albuterol Sulfate Nebulization Solution. *An 8/1/24 self-administration of medication evaluation did not include the medications he was able to self-administer. Interview on 10/17/24 at 11:20 a.m. with DON B regarding self-administration of medication evaluations revealed: *Self-administration of medication evaluations were to be completed for residents who wanted to self-administer medications. -This evaluation was completed by a nursing staff member on a quarterly basis. *She confirmed that the 8/1/24 self-administration of medication evaluation for resident 25 did not include what medications he was able to self-administer. -Her expectation was for the medications to be	F 658		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 32 listed on the evaluation. 6. Review of the provider's October 2023 Resident Assessments policy revealed: *"The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments." *"All members of the care team, including licensed and unlicensed staff members, are asked to participate in the resident assessment process." 7. Review of the provider's undated Conformity with Laws and Professional Standards policy revealed: *"Our facility operates and provides services in compliance with current federal, state, and local laws, regulations, codes and professional standards of practice that apply to our facility and types of services provided." *"Our facility's policies, procedures, and operational practices are developed and maintained in accordance with current accepted professional standards and principles as well as current commonly accept health standards established by national organizations, board and councils". *"Our facility has developed written policies and procedures that govern day-to-day operation and such policies and procedures are reviewed at least annually."	F 658		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686	Corrective Action Resident 3s pressure injuries were assessed, documented, had POA and physician notified on 10/17/2024 by ADON. Treatment orders were received and entered on resident's TAR on 10/17/2024.	11/9/2024

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F 686	Continued From page 33 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview, observation, record review, and policy review, revealed the provider failed to ensure one of one sampled resident's (3) pressure injuries had been identified, assessed, documented, and her physician was notified. Findings include: 1. Interview on 10/16/24 at 8:05 a.m. with director of nursing (DON) B regarding resident 3's Stage III pressure ulcer that was listed on the facility provided Matrix revealed that pressure ulcer was healed at the beginning of September 2024. Interview on 10/17/24 at 10:09 a.m. with certified nursing assistant (CNA) N regarding resident 3's skin concern revealed: *She had "sores" on her buttock and on her inner thigh, "one [is the] size of [a] quarter [the] other's [the] size of [a] dime". -She had "sores" on her heels in the past, but currently did not. *She had notified licensed practical nurse (LPN) M of the "sores". Interview on 10/17/24 11:05 AM with CNA I regarding resident 3's skin revealed:	F 686	Identification of Others All residents will have a skin assessment completed by a licens ed nurse before 11/9/2024. All identified skin concerns and pressure injuries were reviewed to ensure accurate documentation, treatments are ordered, physician and resident or responsible party notification was made. Systemic Changes Required Directed in Service Training. Administrator, DON, IDT and Medical director did create and approve Pressure Injury Assessment and Documentation protocol to address timely assessment and documentation and timely notification and intervention initiation of skin/pressure injury. Administrator, DON, IDT and Medical director did review, and accept Comprehensive Assessment of Residents Policy, Pressure Ulcers/Skin Breakdown-Clinical Protocol on 11/8/2024. Education: All education will be given to designated staff on or before 11/9/2024. Those who have not received the education prior to 11/9/2024 will be given education prior to working next shift. Education to ensure interventions are appropriate based on resident. All direct care staff are educated on the Prevention of Pressure Injuries Policy and roles and responsibilities to report skin concerns or changes, detailed location of concern, and initiate proactive preventative measures to prevent pressure injuries. Required Directed in Service Training. All licensed and unlicensed staff are educated on their role and responsibility to for ensuring skin care concerns and changes to skin are reported timely to licensed nurse, skin concerns are addressed timely and proactively. Education on role and responsibilities of preventing pressure injuries, ensuring interventions are followed per the care	

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F 686	Continued From page 34 *She had a "little tiny one [sore]" "in between her thighs". -She thought a nurse was aware. Interview on 10/17/24 at 11:29 a.m. with DON B regarding resident 3's skin condition revealed: *She did not currently have any pressure injuries. -She had pressure injuries on both of her heels in the recent past that had healed. Review of resident 3's electronic medical record (EMR) revealed: *Nurse's progress notes that indicated: -On 9/6/24 "area of breakdown to the back of Achilles heel". --"The areas are not open and the L [left] heel at 1.5 cm [centimeters] long is worse that the R [right] at 1.0 cm long. Both measuring approximately 0.6 cm wide. Origin unknown." -On 9/11/24 "Resident has two pressure areas to bilateral heels. R heel measurement (cm): 0.3 x 0.3 L heel measurement (cm) 0.4 x 1.4. Right heel is a small fully ruptured blister thathas [that has] a small open area where all fluid has drained out and epithelial tissue remains intact otherwise." -On 9/18/24 "Resident had been on weekly wound rounds for a small blister to each heal [heel] and both are now healed." Observation and Interview on 10/17/24 at 3:00 p.m. with assistant director of nursing (ADON) C regarding resident 5's skin concern revealed: *Left proximal posterior upper leg with an open area that was an approximate size of 0.4 cm by 0.4 cm open area with 2 cm by 6 cm of raised nonblanchable skin surrounding the open area. *Left proximal posterior heel at approximately 0.2 cm x 0.5 cm that she identified as a suspected	F 686	plan, identification of potential new interventions to prevent pressure injuries, and the facilities capabilities, equipment and measures available to prevent pressure injuries, as well as discussing with IDT or licensed nurses on personalized suggestions for pressure injury prevention. Education to ensure residents receive care, consistent with professional standards to prevent pressure injuries. Education to IDT to ensure documentation and care planning of pressure injuries to demonstrate avoidable and unavoidable pressure injuries based on the resident's clinical condition, prevention measures are reviewed with new pressure injuries, resident receives necessary treatments and services to promote healing, prevent infection and prevent new pressure injuries from developing. Education to ensure providers are updated on wounds-location, stage, and measurements, support risk factors, and actively participate in the treatment and assessment of wounds. Monitoring All monitoring will be done three times weekly until a lessor frequency is determined by the IDT/QAPI committee. DON or designee will monitor to ensure staff are providing timely notification to nurse of skin concerns or changes, licensed nurses are completing assessments timely and accurately, obtaining and initiating treatment orders, notifying resident/representative and provider, and identifying risks, documenting demonstration of avoidable and unavoidable pressure injuries and contributing factors. DON or designee will monitor to ensure staff are competent on their role and responsibility to identify, notify, follow care plan interventions, and prevent pressure injuries.	

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F 686	Continued From page 35 deep tissue pressure injury. *ADON C confirmed that she was not previously aware of resident 3's current skin issues, she "wishes someone would have told me about it." Interview on 10/17/24 at 3:15 p.m. with registered nurse (RN) T regarding resident 3's skin condition revealed: *Her thighs were excoriated (skin was wearing off). *No staff member had asked for a silicone patch to be placed on her skin to assist in the prevention of a pressure injury. -She was not aware of resident 3 having pressure injury. Interview on 10/17/24 at 3:19 p.m. with RN J regarding resident 3's skin condition revealed: *She completed a skin assessment on 10/16/24. -She had "looked at [her] bottom and looked at [her] heel" she had not "seen anything unusual". -After discussion of resident 3's pressure ulcer's on her posterior upper leg and posterior heel she stated, "Those don't happen overnight". Interview on 10/17/24 at 3:30 p.m. with CNA N regarding resident 3's skin condition revealed: *She had notified nurse licensed practical nurse M a week previous that her "bottom" was "open at that time" and it "wasn't big but open, right where [her] leg and butt cheek connect." *She stated she thought other nurses had been aware of the skin concern. Interview on 10/17/24 at 3:35 p.m. with DON B regarding resident 3's current pressure injuries revealed: *She confirmed the pressure injuries had not been assessed, documented, and her physician	F 686	DON or designee will monitor to ensure provider is updated on new or changed wounds, support risk factors, and participate in treatment and assessment of wounds.	

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F 686	Continued From page 36	F 686		

notified.
*Her expectation for pressure injuries was that:
-A professional nurse was to complete a full head-to-toe skin assessment.
-The resident's physician was to be contacted with any concerns.
-A risk management report was to be completed.

Review of the provider's April 2018 Pressure Ulcers/Skin Breakdown-Clinical Protocol policy revealed:
*"The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s)."
*"In addition, the nurse shall describe and document/report the following:
-a. Full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue;"

Review of the provider's March 2020 Pressure Injuries Overview policy revealed:
*"Staging (National Pressure Injury Advisory Panel Classification System)"
*"Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration"
-"Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation reveals a dark wound bed or blood-filled blister."
-"This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface."
*"The wound mat [may] evolve rapidly to reveal the actual extent of tissue injury, or many [may] resolve without tissue loss."

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F 804 SS=F	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 policy review, the provider failed to ensure: *Food plated for residents who received late, in-room mealtrays during one of one observed meal service were served at an appetizing temperature. *One of one resident's (43) room trays were delivered in a timely manner to ensure food temperatures were appetizing during two of two observed meal services. Findings include: 1. Observation on 10/16/24 from 5:05 p.m. through 6:10 p.m. of the evening meal service and interviews with cook F during that same time revealed: *Food for the evening meal was temped in the kitchen before placing it on the steam table in the main dining room (MDR) prior to serving. -Hot foods were all at an acceptable serving temperature. *Cook F plated the evening meals for residents in the following order: -"Regular" room trays (room trays for residents who regularly ate their meals in their rooms), the Bistro dining room, the MDR, and "late trays"	F 804	Corrective Action No immediate corrective action can be taken for Resident 43's meal temperatures and timely delivery of room tray. Resident 43 passed away 10/19/2024. Identification of Others All residents who get meal trays are at risk. Facility Advocate rounds were updated and started on 10/31/2024 to include asking all residents of any meal concerns they have. Facility will address meal concerns as reported. Dietary manager confirmed both sides of the plate warmer work on 11/4/2024. The light does not work on one side, but heat does. Systemic Changes Directed In Service: IDT, RD and Medical director did review and approve 2019 Food Temperatures policy, 2019 In-Room Dining (Room Service) policy and 2019 Early and Late Meals policy on 11/8/2024. Facility has changed nursing aide shift times to overlap 1 hour at each shift to allow increased staffing. Facility dietary aides will begin passing all trays as soon as they are delivered to prevent trays from getting cold while waiting for nursing staff t o deliver. Facility has made adjustments: Dietary plate warmer temperature was increased. Facility has made purchases: Plate warmer dome to keep plates covered and hot when in plate warmer, knobs for steam tables to accurately set temperature, Tray plate complete covers, bottom and top, that are thermal to retain heat, Meal tray cart that will preserve heat when transporting trays to room. Items were ordered 11/4/2024 knobs ordered on 11/4/24. A small Freezer has been	11/9/2024

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F 804	Continued From page 38 (residents who usually ate in the Bistro or the MDR but had chosen to eat in their rooms for that meal). *At 5:05 p.m. cook F began plating the regular room trays using plates removed from a dual plate warmer. -Plates inside the two cylinders of the warmer rose six to eight inches above the lip of each cylindher cylinder opening that prevented those plates from being warmed. *A red light on the right side warmer was lit which indicated the warming cylinder was on but the light on the left side warmer was unlit. -Cook F thought the left side warmer may not have been working properly. *Instructions on top of the warmer read: "Adjust thermometer inside tube." -Cook F had not known at what temperature the thermometer inside each tube was set at.. *Maintenance director D was responsible for making temperature adjustments to the warmer. -She had not discussed her concerns regarding the left side warmer with him. *Regular room trays and the portable steam table used to serve meals in the Bistro left the MDR for resident distribution at 5:15 p.m. *Residents sitting in the hall outside of the MDR were allowed into the MDR at 5:15 p.m. -MDR residents were scheduled to receive their meals at 5:30 p.m. *Between 5:15 p.m. and 5:30 p.m. cook F and dietary aide R had taken drink orders from the residents in the MDR and assisted them to complete their menus for the following days meals. -During that same time, the food containers on the steam table had been left uncovered. *Cook F stated the only food-related complaint she had heard from residents was lately their	F 804	provided in the Bistro on the counter to keep ice cream that is to be served with meals frozen during serving time. Education: All education will be given to designated staff on or before 11/9/2024. Those who have not received the education prior to 11/9/2024 will be given education prior to working next shift. Education to ensure interventions are appropriate based on resident. Education to all staff on facility changes with nursing hours, dietary duties, and most effective ways to use dietary tray plate covers and cart, timely passing of meal trays to reduce heat loss from food. All food should be covered and delivered as soon as possible after plating to maintain food quality and temperature. It will remain the responsibility of the nursing staff to ensure trays are delivered by dietary staff and nursing staff will deliver trays to residents who require assistance with meals. Nursing staff will be responsible for ensuring residents who are receiving meal trays are ready prior to tray delivery, for ensuring residents who require assistance with meal trays are being assisted as soon as possible after the trays arrive at the nursing unit. Education includes the requirements that residents receive, and the facility provides: Food prepared by methods that conserve nutritive value, flavor, and appearance; Food and drink that is palatable, attractive, and at a safe and appetizing temperature. If a resident does not touch the food on their meal tray or at the table, dietary or nursing needs to follow up with the resident why they did not eat. If it was because the food was cold, offer to warm up the food, or offer an alternative. If residents' food is returned to the kitchen for any reason, the resident should be updated on why his food is not being delivered and ensure residents are getting drinks as ordered.	

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F 804	Continued From page 39 food had been cold. *At 5:40 p.m. plating and serving of the evening meal for residents in the MDR began. *At 6:00 p.m. the following temperatures were taken from the uncovered food containers on the steam table immediately before the late resident room trays were plated: -Mashed potatoes/122 degrees Fahrenheit (F), asparagus/102 degrees F, gravy/78 degrees F, and fish/80 degrees F. *Cook F indicated she had lowered the temperature on the steam table so the gravy would not burn. -That had likely affected the temperatures of all the other food held on that steam table. -The length of time it had taken to serve all the residents, the uncovered containers on the steam table, and the possibility the plate warmer may not have been functioning properly and may also have contributed to the low food temperatures. *Frozen ice cream cups were the dessert for that same evening meal. -A box of 48 stacked ice cream cups sat directly on top of a "Blue Ice" re-usable freezer pack in the MDR food serving station area. *Cook F confirmed the ice cream cups were soft and runny by the time they were served to residents who received late trays. 2. Observation and interview on 10/17/24 at 9:15 a.m. with maintenance director D of the dual plate warmer revealed: *The temperature gauge inside of both warmers was set between 1 and 2. -The plate warmer guide inside of the warmers regarding plate warmer temperatures indicated the following: "Warm=1 and 5=Hot". Interview on 10/17/24 at 4:30 p.m. with	F 804	If hot tea is ordered, it should come with hot water, not coffee or warm water. Directed in Service: Think like the resident is you at a restaurant. How would you feel? How would you like your meal delivered? Would you be okay if your food was delivered an hour after you expected it? How would you feel if your food was forgot, and no one checked on you? Food is expected to be prepared and served at a temperature that is palatable, has flavor that increases likeness and consumption, food is safe to eat and looks appetizing. Dining is the most pleasurable part of the day for most residents. Dining should be enjoyable, aesthetic, pleasurable, safe and nutritious. Education to dietary staff to use plates from the plate warmer that are not on top above the heating element, to report to maintenance for any concerns of equipment not working properly. Education includes hot food should be served at a temperature of 135 degrees. Cold food must be served cold. Frozen food must be served Frozen. Temps include preparing trays. Meal servers should only take out a few items of cold or frozen selections at a time to prevent melting. Meal cart use that includes options for heating cart prior to putting trays in Temps should not be lowered on the steam table. Options of placing the food pan on top of tray with hot water and putting it into steam table will prevent burning of food in steam table while keeping food hot, or refilling steam table and not putting so much in at one time to prevent burning of food. Keep food on steam table covered to preserve heat. Food needs to be served as soon as possible after temperatures have been taken and food has been put onto the steam table. Dietary aide can begin delivering drinks prior to mealtime while	

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F 804	Continued From page 40 administrator A regarding food holding temperatures revealed: *Hot food temperatures were not held and served at an expected temperature of at least 135 degrees F. *Frozen food was not kept at a temperature to prevent thawing from occurring. *There were opportunities to improve the food service delivery process to ensure food temperatures for all meal services were kept at an appetizing temperature. 3. Observation and interview on 10/15/24 at 12:47 p.m. with resident 43 while in his room located in the 200-hallway revealed: *He was fully reclined in his recliner chair with oxygen being delivered by nasal cannula. *He stated he attended renal dialysis on Mondays, Wednesdays, and Fridays. *He had requested the noon meal to be delivered to his room. *He stated: -He hoped his food would arrive soon because he was hungry. -"I never know when I will get it [this meal tray]." -It was his preference to eat his meals in his room so he could avoid sitting on a sore that was on his tailbone. -The hot food was always cold by the time the meal trays arrived. -He did not like most of the foods that were served to him. -He had quit filling out the meal preference sheets because he never received what he had ordered. -He sent his meal trays back to the kitchen in the past, but no alternatives were offered, and his food was never heated up and returned, so he had quit asking.	F 804	the cook is temping and transferring food to the steam table to start serving at the start of meal time. Meal choices need to be followed by diet and resident choices when filling out the menus. Dietary staff need to make sure they are providing items from the Always Available menu when they are being requested or give the resident an update on how long it will take. (As soon as possible). Residents should be able to request items from the Always Available Menu at any time of the day, evening or night. Monitoring All monitoring will be done three times weekly until a lessor frequency is determined by the IDT/QAPI committee. Dietary manager or designee will monitor dietary staff to ensure: -Staff are using the plate warmer appropriately, keeping plates hot until food is served on the plates; -staff are reporting to maintenance any concerns of equipment not working properly; Staff are following ways to ensure -hot food is being served at 135 degrees -cold food is being served cold -frozen food is being served frozen; -Steam table is being used appropriately, temp is not turned down, food is covered, refilling food as needed to prevent burning in steam table or using alternative methods to prevent burning; -food is being served as soon as possible after temp is checked; meal choices are followed as resident requests on menu and per diet -dietary staff are providing items from the always available menu when requested or updating resident on time frame -residents are allowed to request items from the always available any time, including outside of meal times – staff are heating up tray cart prior to putting food in cart	

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F 804	Continued From page 41 Interview on 10/15/24 at 12:55 p.m. with dietary aide Q regarding meal tray service to the resident rooms revealed: *The noon meal service started at noon. *She stated the late room trays were normally delivered at 12:40 p.m. following the dining room meal service, but she was "running a little bit late." -There were "early" meal trays that were delivered before the dining room service for those who always stayed in their rooms, and "late" meal trays were delivered following the dining room service for those residents who occasionally requested a tray for their room. Further interview on 10/15/24 at 1:04 p.m. with resident 43 in his room revealed he had not received his noon meal tray and he stated he was becoming angry because he was very hungry. Observation on 10/15/24 from 1:09 p.m. through 1:27 p.m. of the nurse's station adjacent to the 200-hallway revealed: *At 1:09 p.m. the plated and covered meal trays were delivered on a cart to the nurse's station, and staff were notified by walkie-talkie that the trays were ready to be delivered. *At 1:12 p.m. the tray cart remained sitting by the nurse's station while four unidentified staff members visited behind the nurse's desk. *At 1:19 p.m. an unidentified resident walked up to the covered meal tray cart and lifted the lid off a tray to view the food, removed a lid off a drink, took a sip, and then replaced those lids. -That tray was immediately removed from the cart by a staff member and taken back to the kitchen. -That meal cart was then taken down each hallway for delivery of the "late" room trays.	F 804	DON or Designee will monitor staff to ensure -staff understand the use of the tray covers and cart, -timely passing of meal trays -nursing staff are ensuring trays are delivered by dietary staff and nursing staff are delivering trays to residents who require assistance – Nursing staff are ensuring residents eating in their rooms are ready prior to meal tray delivery -following up with the resident if they have not touched their food (why, offer other options or heating food up) -following up with resident if meal tray is delayed -drinks are delivered as ordered (hot tea with hot water and tea bag)	

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	435035	A. BUILDING ______ B. WING ______	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE BELLE FOURCHE, SD 57717

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F 804	Continued From page 42	F 804		

-An unidentified aide walked the meal cart past resident 43's room twice without delivering any food to him nor explaining to the resident why his tray was late. Resident 43 continued to wait for his lunch meal.
*At 1:27 p.m. resident 43 was delivered a noon meal tray to his room.
-That was eighteen minutes after the meal cart had been delivered to the nurse's station and over forty-five minutes past the normal "late tray" delivery time.

Observation and interview on 10/15/24 at 1:27 p.m. and at 3:47 p.m. with resident 43 following delivery of his noon meal tray revealed:
*He stated his pulled-meat barbeque sandwich and his potato wedges were cold.
-He had requested hot water and a green tea bag and was served a cup of slightly warm coffee along with a sealed green tea bag. He had no hot water for the tea bag.
*He stated, "I'll eat the coleslaw only. It's [the food] crap. It's always cold."
*At 3:47 p.m., observation of resident 43's room revealed his noon meal tray remained sitting on his table next to his recliner with the uneaten barbeque sandwich and potato wedges.

4. Observation, interview, and food temperature monitoring on 10/16/24 from 5:28 p.m. through 6:25 p.m. with resident 43 and his former wife while he awaited a meal tray to be delivered to his room revealed:
*His meal tray arrived at 5:29 p.m. and contained baked fish with an internal temperature of 100.4 degrees, mashed potatoes at 103.7 degrees, and asparagus at 90 degrees.
-The resident stated he hated fish and that he would only eat the asparagus.

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-His ice cream cup dessert had melted and was mostly liquified.
-He admitted he had not filled out a meal preference ticket for that meal and stated, "It's a waste of time because they won't give me what I want."
*At 5:30 p.m., he asked his former wife to order him some chicken noodle soup. She went to the adjacent nurse's station and placed a request for the soup.
*At 6:25 p.m. he had not received his requested soup and no staff had come into his room to check on his meal or to remove his meal tray.

Interview on 10/16/24 at 6:26 p.m. with assistant director of nursing (ADON) C who was at the adjacent nurse's station regarding the soup request for resident 43 revealed:
*None of the four staff members who were at the nurse's station had been there when the resident's former wife requested the soup at 5:30 p.m.
*ADON C stated, "Whoever was at the desk should have called the kitchen on the phone."

Interview on 10/16/24 at 6:27 p.m. with dietary aide (DA) R in front of the adjacent nurse's station while he was pushing the meal cart with used meal trays to the kitchen revealed:
*He confirmed he had heard about resident 43's request for soup.
-He stated, "I think we forgot. I'm sorry."
*He confirmed having to wait nearly an hour for an alternative meal of soup was unacceptable.
-He stated he was "not in charge" of alternative meals and the person who oversaw fullfilling alternative meal requests was cook F.

Interview on 10/16/24 at 6:29 p.m. with cook F

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F 804	Continued From page 44	F 804		

regarding resident 43's soup request revealed:
*She stated:
-"We didn't get it written down and it went out of our brains."
-"I can get it right away if the aides would come and wait for it."
-"We could use another person as we only have three people to serve two dining rooms."
*She confirmed it was not acceptable to forget an alternative meal request made by a resident.

Interview on 10/16/24 at 6:35 p.m. with resident 43 while in his room revealed he stated he was tired from attending dialysis that day and wanted to lay down in his bed. His soup was delivered at that time, and he stated it was not hot enough for his liking but he "would eat it anyway."

Record review of resident 43's electronic medical record (EMR) revealed:
*He was admitted on 5/13/24 following a hospitalization.
*He had a Brief Interview of Mental Status (BIMS) score of 15, indicating he was cognitively intact and could make his own decisions.
*His relevant diagnoses included end-stage renal disease, dependence on renal dialysis, reduced mobility, weakness, renovascular hypertension, limitation of activities due to disability, atherosclerotic heart disease, hypertensive heart disease, pleural effusion, hypocalcemia, hyperlipidemia, hypomagnesemia, hyperuricemia, non-ST elevation myocardial infarction (NSTEMI), secondary hyperparathyroidism of renal origin, chronic pain, and a stage 4 pressure ulcer of the sacral region.
*He was receiving comfort care services (a type of medical treatment that focuses on improving a patient's quality of life and comfort, rather than

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F 804	Continued From page 45	F 804		

extending their life, and is often used for patients who are near the end of life).
*He was admitted with a renal diet order, but the dietary order was changed to a regular diet on 7/24/24 because he was refusing most of his meals on the renal diet.
*He had orders for an Ensure supplement drink once a day, along with Nepro and Prostat supplement drinks which he was refusing. He stated, "They taste awful."
*He was on a two gram low sodium diet and a 1,200 ml (milliliter) fluid restriction which was being monitored and documented every shift.
*His weight would fluctuate daily depending on dialysis but he had remained stable, within five pounds, since his admission.

Interview on 10/17/24 at 4:26 p.m. with administrator A regarding resident 43's meal service and food temperatures revealed:
*She confirmed the holding temperatures of the foods could have been higher to maintain a more palatable temperature.
*She was aware of what had occurred regarding his meal tray deliveries and his request for soup. She stated there needed to be a better way to deliver the meal trays to resident's rooms in a timelier manner.

Review of the provider's 2019 Food Temperatures policy revealed:
*"1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees F (fahrenheit)."
*"3. Temperatures should be taken periodically to assure hot foods stay above 135 degrees F..."

Review of the provider's 2019 In-Room Dining

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F 804	Continued From page 46 (Room Service) policy revealed: *"Procedure:" -"1. d. Insulated plate covers, coffee pots, mugs and bowls will help maintain food temperatures during delivery. All foods should be covered and delivered as soon as possible after plating to maintain food quality and temperature." -"3. h. Hot food must be hot and cold food must be cold (as acceptable to the individual being served)." Review of the provider's 2019 Early and Late Meals policy revealed: *"Procedure:" -"3. Upon arrival on the nursing unit, it is the responsibility of the nursing staff to see that the meals are passed and individuals receive assistance as quickly as possible." *"Late Trays:" -"2. After the meal is served, the cook/chef will reserve enough food for the meals that will be served later. Food should be held safely at the proper temperatures." -"3. ...The nursing staff on the unit will prompt [promptly] serve the meal to assure proper food temperatures."	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.	F 812	Corrective Action The Bistro refrigerator has been removed from the Bistro. Undated, unmarked, expired Pizza, yogurt, pepperoni, pies, cottage cheese, sandwiches, frozen meal, ice cream, blizzard were all removed on 11/1/2024 Walk in refrigerator in kitchen was inspected and undated or expired sandwiches and beef were removed 11/1/24.	11/9/2024

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F 812	Continued From page 47 (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 food items in one of one Bistro refrigerator/freezer and one of one walk-in refrigerator in the kitchen were properly labeled, dated, and/or covered. Findings include: 1. Observation on 10/15/24 at 4:50 p.m. in the Bistro kitchenette revealed: *A sign on the refrigerator: "This fridge is for resident use only. Anything placed in this fridge for residents needs to be labeled with room number and the date it is placed." "Anything in this fridge without a date or label will be thrown out." *Inside of the refrigerator were the following observed food items: -Two pieces of pizza in an undated and unlabeled plastic bag. -One unopened container of Yoplait peach yogurt marked with a resident room number and dated "8/9." The best by date on that container was 9/15/24. -Multiple pieces of sliced pepperoni in an undated and unlabeled plastic bag. -Half of a covered chocolate cream pie that was undated and unlabeled.	F 812	Identification of Others Dietary Manager inspected large refrigerator and freezer in Bistro, the walk-in refrigerator and freezer in kitchen and removed any undated, outdated, uncovered, or unlabeled items on 11/6/2024. Systemic Changes A refrigerator has been provided for staff to use away from resident used appliances. Checking refrigerators and freezers have been added to dietary staff daily duties. IDT and Medical director did review and 2019 Food and Nutrition Services in Healthcare Policy and Procedure Manual on Food Production and Food Safety on 11/8/2024. Education: All education will be given to designated staff on or before 11/9/2024. Those who have not received the education prior to 11/9/2024 will be given education prior to working next shift. Education will be given to all staff on the Food and Nutrition Services Policy regarding Food Production and Food Safety. Education to ensure staff know leftovers must be dated, labeled, covered, cooled and stored in a refrigerator. Education that the facility must adhere to State and local laws or regulations on storing, preparing, distributing and serving food in accordance with professional standards for food service safety. Education will include any item not covered, partially covered, or the cover has come off, must be discarded, all food not labeled, must be discarded, food prepared and cooked will be discarded after 3 days. The day to discard food is the date labeled.	

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F 812	Continued From page 48 -One unopened container of cottage cheese marked with a best by date of 10/7/24. -One piece of covered cherry pie in an undated and unlabeled plastic dish. -Two ham sandwiches in an undated and unlabeled plastic container. *In the freezer the following food items were observed: -A Lean Cuisine chicken parmesan dinner with a best by date of March 2024. -One carton of vanilla ice cream with a best by date of 9/7/24. -An uncovered chocolate Dairy Queen Blizzard cup with a spoon frozen inside of it. Observation on 10/16/24 at 4:45 p.m. of the walk-in refrigerator in the kitchen revealed: *Three undated cellophane-wrapped meat and cheese sandwiches. *One stainless steel container covered with torn aluminum foil labeled "Beef for sandwich 10/14." Telephone interview on 10/17/24 at 2:00 p.m. with dietary manager E revealed: *The task of removing outdated food items was just added to kitchen staffs' weekly cleaning checklist. *No food items were to have been placed in any refrigerator or freezer without first properly covering, dating, and labeling that food item. Review of the provider's 2019 Food and Nutrition Services in Healthcare Policy and Procedure Manual revealed: *Food Production and Food Safety: -"4.d. Leftovers must be dated, labeled, covered, cooled and stored in a refrigerator."	F 812	Education includes to be checking all food or drink items for expiration daily such as yogurts, applesauce, drinks, condiments, and other facility provided food and drink items. Education includes ensuring the same requirements are followed for any food a resident or representatives requests be stored or saved for a later time, all items must be labeled, covered, cooled, stored in refrigerator or freezer for up to 3 days if item has been open. If item has not been open, staff will follow manufacturer expiration dates. Monitoring All monitoring will be done three times weekly until a lessor frequency is determined by the IDT/QAPI committee. Dietary Manager or designee will monitor fridge and freezers in kitchen and bistro to ensure any food stored is dated, labeled, and covered, covers on food are not tore, ripped, or removed, staff are aware of labeling leftovers to be discarded after 3 days, and staff are aware that items stored per resident or representative requests must adhere to the same requirements, all items must be labeled, covered, cooled, stored in refrigerator or freezer for up to 3 days if item has been open. If item has not been open, staff will follow manufacturer expiration dates.	

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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 on October 15, 2024. Rolling Hills Healthcare was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at E004 and E039 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:	E 004	Corrective Action Facility reviewed emergency plan agreements. All agreements were sent to other parties for approval and annual update before 11/9/2024. Identification of Others No other agreements are in place for Emergency Preparedness requiring annual updates. Systemic Changes LNHA and Maintenance Director will review Emergency Plan agreements yearly to ensure agreements are updated annually. Monitoring LNHA will monitor Emergency Preparedness Plan annually for one year to ensure all agreements are updated annually.	11/9/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: T Harwood
TITLE: Licensed Nursing Home Administrator
(X6) DATE: 11/9/2024

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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E 004	Continued From page 1 * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to update the emergency preparedness plan agreements (emergency drinking water supply, evacuation transfer, and evacuation shelter) annually. Findings include: Record review on 10/15/24 at 2:45 p.m. revealed no documentation the provider's current emergency preparedness plan memorandums of understanding/agreements were updated annually. For example, the emergency drinking water agreement copy originally signed 12/19/18 had added notes stating the agreement was verified by email on 2/24/22.	E 004		

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E 004	Continued From page 2 Interview with the administrator on 10/15/24 at 3:00 p.m. confirmed that finding. She indicated the agreements had language that stated they would automatically renew annually.	E 004		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of	E 039	Corrective Action The facility has reached out to the Belle Fourche Fire Department and Butte County Emergency Management to schedule an exercise. Identification of Others The facility is at risk related to all community based exercise requirements. Systemic Changes Maintenance Manager will work with Butte County Emergency Management to ensure facility is involved in South Dakota and Butte County full-scale community exercises or alternative tabletop workshops to be completed annually. Monitoring LNHA or designee will complete quarterly monitoring to meet the Emergency Plan testing requirements: Complete one of the following annually: Participate in an annual full-scale exercise that is community-based. Conduct an annual individual, facility-based functional exercise. Exempt if facility experiences an actual natural or man-made emergency that requires activation of the emergency plan	11/9/2024

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E 039	Continued From page 3 this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited	E 039	Conduct one of the additional annual exercises: A second full-scale exercise that is community-based An individual, facility based functional exercise 1. A mock disaster drill A tabletop exercise or workshop	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435035	A. BUILDING ______ B. WING ______	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE BELLE FOURCHE, SD 57717

(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
E 039	Continued From page 4 to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435035	A. BUILDING ______ B. WING ______	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE BELLE FOURCHE, SD 57717

(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
E 039	Continued From page 5 challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E 039		

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	435035	A. BUILDING ______ B. WING ______	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE BELLE FOURCHE, SD 57717

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E 039	Continued From page 6 plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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	435035	A. BUILDING ______ B. WING ______	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE BELLE FOURCHE, SD 57717

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E 039	Continued From page 7 (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435035	A. BUILDING ______ B. WING ______	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE BELLE FOURCHE, SD 57717

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E 039	Continued From page 8 [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at	E 039		

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	435035	A. BUILDING ______ B. WING ______	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE BELLE FOURCHE, SD 57717

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E 039	Continued From page 9 least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435035	A. BUILDING ______ B. WING ______	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE BELLE FOURCHE, SD 57717

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E 039	Continued From page 10	E 039		

following:
(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.
(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

*[RNCHIs at §403.748]:
(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:
(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the provider failed to conduct a full-scale community-based exercise for emergency preparedness from 2023 to 2024. Findings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435035	A. BUILDING ______ B. WING ______	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE BELLE FOURCHE, SD 57717

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E 039	Continued From page 11 include: 1. Record review on 10/15/24 at 2:45 p.m. revealed no documentation a full-scale community-based exercise was conducted to test the emergency plan for 2023/2024. Interview with the maintenance supervisor on 10/15/24 at 3:15 p.m. confirmed that finding.	E 039		

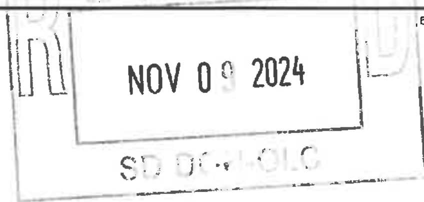
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10594	A. BUILDING: ________ B. WING ________	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE BELLE FOURCHE, SD 57717

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/15/24 through 10/17/24. Rolling Hills Healthcare was found not in compliance with the following requirement: S206.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on	S 206	Corrective Action CNA P is no longer employed effective 11/1/2024. No corrective action can be taken. Identification of Others All re-hired employees are at risk. Systemic Changes LNHA reviewed hire dates for all staff. Any staff who have not received their annual education in the last 12 months will receive education on or before 11/9/2024, or prior to working their next shift. Education: All education will be given to designated staff on or before 11/9/2024. Those who have not received the education prior to 11/9/2024 will be given education prior to working next shift. Education to all staff on the Administrative Rule of South Dakota on the annual training requirement on the 11 mandatory education topics: Fire prevention/response, Emergency procedures/preparedness, Infection control & prevention, Accident prevention safety procedures, Proper restraint use, Resident rights, Confidentiality of resident information, Mandatory reporting, Care of residents with unique needs, Dining assistance, nutritional risks, hydration, Abuse, neglect, misappropriation, mistreatment.	11/9/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
THarwood	Licensed Nursing Home Administrator	11/7/2024



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10594	A. BUILDING: ______ B. WING ______	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE BELLE FOURCHE, SD 57717

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 206	Continued From page 1 facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based of employee personnel records review and interview, the provider failed to ensure ongoing training was completed for one of one re-hired sampled employees (P). Findings included: 1. Review of employee personnel records revealed: *Certified nursing assistant (CNA) P had previously worked for the provider from February 2023 through June 2023. *She was re-hired on 1/24/24. *There was no documentation that she had completed the following 11 mandatory education topics: -Fire prevention/response. -Emergency procedures/preparedness. -Infection control & prevention. -Accident prevention safety procedures. -Proper restraint use. -Resident rights. -Confidentiality of resident information. -Mandatory reporting. -Care of residents with unique needs. -Dining assistance, nutritional risks, hydration. -Abuse, neglect, misappropriation, mistreatment. Interview on 10/17/24 at 11:08 with administrator A revealed she: *Had staff complete the eleven mandatory topics upon hire and annually. *Had an all-staff annual training twice yearly to cover the eleven mandatory topics. *Confirmed there was no documentation to support that employee P had completed her mandatory topics upon hire.	S 206	Monitoring All monitoring will be done monthly, for a minimum of 2 months, until a lessor frequency is determined by the IDT/QAPI committee. LNHA or designee will monitor all staff to ensure staff are receiving training on the 11 mandatory education topics as defined in the Administrative Rules of South Dakota 44:73:04:05 Personnel Training.	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10594	A. BUILDING: ____ B. WING ____	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	**2200 13TH AVE BELLE FOURCHE, SD 57717**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 206	Continued From page 2 *Confirmed that employee P had not attended the all-staff annual training in April 2024.	S 206		
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 10/15/24 through 10/17/24. Rolling Hills Healthcare was found in compliance	S 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435035	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**10/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	**2200 13TH AVE** **BELLE FOURCHE, SD 57717**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 10/15/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Rolling Hills Healthcare was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
THarwood	Licensed Nursing Home Administrator	11/9/2024

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.