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 06/27/2024

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 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 6/27/24. Areas surveyed included a resident elopement and a resident fall from a tub chair. Rolling Hills Healthcare was found not in compliance with the following requirement: F658 and to have past noncompliance at F600.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, observation, and policy review, the provider failed to ensure the safety of one of one sampled resident (2) who had fallen from a tub chair when the lap belt (a belt to secure the resident into the chair) was not appropriately placed. This citation is considered past non-compliance based on review of the corrective	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
THarwood	Tracy Harwood	Licensed Nursing Home Administrator	7/19/2024

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 600	Continued From page 1 actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 5/15/24 SD DOH FRI revealed: *On 5/15/24 at 5:30 a.m. resident 2 fell out of the tub chair. -The lap belt that was to be used to secure a resident into the tub chair had not been placed around resident 2. -The resident was assessed at the facility and found to have no apparent injuries. -The facility received physician orders to transfer her to the emergency room (ER) for X-rays. -The X-ray results were negative for bone fractures. -ER evaluation identified she had low blood pressure. The provider implemented systemic changes to ensure the deficient practice does not recur was confirmed after: record review revealed the facility had followed its quality assurance process, education was provided and competencies were provided to all staff who provided bathing assistance to residents, a secondary belt, for the chest area, was purchased and put into place on the tub chair, audits were being completed that verified the safe use of the tub chair and the securing of lap and chest belts. Based on the above information, non-compliance at F600 occurred on 5/15/24 and based on the provider's implemented corrective actions for the deficient practice confirmed on 6/27/24, the non-compliance is considered past non-compliance.	F 600		

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F 658	Continued From page 2	F 658	Corrective Action:	08/02/2024
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 South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, observation, and policy review, the provider failed to ensure accurate assessment for the elopement risk for one of one sampled resident (1) who eloped (left the facility without staff knowledge) when he entered the code to turn off the alarms on the door to the enclosed patio and courtyard, exited that enclosed courtyard, and walked approximately two blocks from the facility before he was found. Findings include: 1. Review of the provider's 6/24/24 (DATE) SD DOH FRI revealed: *On 6/24/24 at 5:05 a.m. resident 1's walker was found by the courtyard door. -At 5:27 a.m. resident 1 was found in walking in a field. -He was returned to the facility, assessed, and was found with no injuries. Review of resident 1's medical record revealed: *His 5/28/24 SLUMS (a brief screening test for detecting mild cognitive impairment and dementia) score was a 14 out of 30, which indicated he may have dementia. *His 3/20/24 Brief Interview of Mental Status score was a 15, which indicated his cognition was	F 658	DON (Director of Nursing) completed an Elopement Risk Assessment for resident 1 on 06/28/2024 indicating resident 1 is at risk for elopement. Identification of Others: All residents are at risk of an inaccurate elopement risk assessment. DON completed an Elopement Risk Assessment on all current residents as of 7/11/2024. Assessments were completed and care plans updated by 07/11/2024. Systemic Changes: LNHA (Licensed Nursing Home Administrator) has added a discussion focus to the IDT's (Interdisciplinary Team) morning meeting to include reviewing residents who are wandering with risk of elopement, change in behaviors, and Assessments completed with a triggered risk and care plan updates. Facility changed alarm codes on 6/24/2024. Facility moved alarm codes on 6/24/2024 and 6/25/2024. Facility changed alarm reset times on 6/25/2024. DON or designee will provide education to all nurses who complete resident assessments on the facility Wandering and Elopement Policy to include accurate identification of residents who are at risk for unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents, to include new or changes in wandering and behaviors and completion of a new assessment.	

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F 658	Continued From page 3 intact. *His 6/14/24 Elopement Risk Assessment revealed he had no wandering behaviors and was at low risk for elopement. Review of resident 1's 6/27/24 care plan indicated: *A 6/12/24 focus area that included: -He had a diagnosis of dementia with agitation and anxiety. -He wandered outside, into other resident's rooms, hallways, and urinated outside. *Interventions for that focus area included staff were: -To educate him when his behavior included going in and out of other resident rooms, was exit seeking and setting off alarms. -To provide a 1:1 (one to one) visits when he is displaying depressive moods or feeling down, when highly agitated, exit seeking, angry or aggressive. -To escort him outside, provide constant encouragement, and redirection. *A 6/24/24 focus area that indicated he was an elopement risk due to a successful elopement. -He had made statements of wanting to leave, intending to leave, and he had sufficient mobility to exit unescorted. -Staff were to notify his physician of any elopements and to follow the provider's elopement policy. *Additional individualized interventions included staff were to: --Observe him for his knowledge of alarm codes and notify administrator [ADM] A if resident knows codes. Provide constant supervision with 1:1 supervision when he is stated he planned to leave facility. -Offer him to take walks through the courtyard	F 658	DON or designee will provide education to all nurses who complete resident assessments on the Resident Assessment Policy to ensure nurses are including all members of the care team, including licensed and unlicensed staff members, to participate in the resident assessment process. All Education will be completed on or before 08/02/2024. Those who have not received education will receive education before working their next shift. Monitoring: DON or designee will monitor Elopement Risk assessments weekly for all long term care residents who wander and new admissions who wander to ensure accurate identification of residents who are at risk for unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. DON or designee will monitor nurses weekly who complete assessments to ensure all members of the care team are included to participate in the resident assessment process. All monitoring will be conducted as indicated until a lessor frequency is deemed appropriate by the Quality Assurance committee for a minimum of 2 months. Administrator or designee will report any identified trends to the Quality Assurance committee.	

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with staff throughout the day.

Review of resident 1's progress notes revealed:
*On 5/11/24 a nurse's note that included:
-On 5/10/24 at 19:15 (7:15 p.m.) an unidentified certified nurse aide (CNA) had seen resident 1 walking along the street
-"At that time she [CNA] was sitting with the wife, who was in their vehicle. Resident had at some point gotten out of the vehicle and refused to get back in because he refused to come back to the facility."
-"At 19:45 (7:45 p.m.) the cop showed up at the facility with resident."
-Resident (1) "agreed to come into facility, but stated that he intended to leave as soon as staff turned their back."
-"Frequent checks have been made on resident."
*A 6/5/24 certified nurse practitioner note (CNP) that indicated:
He had "intermittent periods of confusion".
-"Has had some desire to exit building, enjoys spending time in the sun. Elopement in past".
*A 6/8/2024 nurse's behavior note that noted, "Resident will not remain in the facility and he has now been going outside to urinate. Resident will not listen to staff redirection. Resident refuses any and all behavior interventions suggested by staff. Cont. [continue] to attempt and monitor."
-A follow-up note to that behavior note that indicated "Staff have tried: distraction, redirection, wii [Wii] games, 1:1, encouraging resident to relax in recliner with feet up, reading a book, conversing with staff, family phone calls. Resident will not accept any interventions and is noncompliant with education given regarding peeing outside and or wandering."
*A 6/9/24 note to redirect him from doors, and to walk with him when he is wandering.

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-He was not easily redirected.
-He did allow staff to escort him outside to the patio.
-He was "worked up and anxious, he has been wandering all shift."

Interview on 6/27/24 at 2:34 p.m. with CNA E regarding resident 1 revealed:
*Resident 1 often went outside to the courtyard and staff would assist him back in.
-There were two doors he would go out, one by the dining room and the other at the end of the hall where he resided.

Interview on 6/27/24 at 2:44 p.m. with licensed practical nurse C regarding resident 1 revealed:
*She thought he was at risk for elopement.
-Staff were monitoring him as he often went towards the courtyard doors.
*Elopement assessments were completed by a nurse when a resident was admitted for care.
-She thought other assessments were done on a quarterly basis.

Interview on 6/27/24 at 2:55 p.m. with CNA G regarding resident 1 revealed:
*On 6/24/24 at 5:00 she arrived at work.
-She heard a "code pink" announcement, which meant a resident was missing.
-The code was to search for resident 1.
*Resident 1 often wandered, and had a history, prior to 6/24/24, of going outside and not telling anyone.
*Resident 1 wore a call light pendant, and staff were to make sure he had it on.
-The call light pendant had been found in his trash can several times.

Interview on 6/27/24 at 3:09 p.m. with director of

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rehabilitation/speech therapist F regarding resident 1 revealed:
*Resident 1 had an elopement on 6/24/24.
*He had "slipped through the courtyard and crossed the field."
*He was exit seeking prior to that incident and he was "normally easy to re-orientate".
*She stated, "The fact that he was previously exit seeking and at home with [the] same behavior I believe is relevant to this specific investigation."

Interview on 6/27/24 at 3:30 p.m. with ADM A and director of nursing (DON) B regarding resident 1 revealed:
*ADM A said on 5/11/24 resident 1 had gone on an outing with his wife.
-He had walked away from her, knowing that she would follow him.
-She thought his wife had "eyes on him at all times", therefore they had not considered it an elopement.
-He had told ADM A "I just wanted to walk."
*DON B thought the 6/5/24 CNP statement documented in resident 1's medical record was a "misstatement".
-They had stated that he had not eloped from the facility prior to 6/24/24 and was not at risk for elopement then.
*ADM A stated they had determined the root cause for his elopement was that he was "angry at his wife for dropping him off [at the facility]".

Interview on 6/27/24 at 3:54 p.m. with resident 1's spouse revealed:
*"About a month ago he had walked away" from her at the store.
-He walked several blocks.
-The police had to come pick him up and return him to the provider's facility.

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*This was the first time that had happened.

Continued interview on 6/27/24 at 4:02 p.m. with ADM A and DON B regarding the accuracy of resident 1's assessments revealed:
*DON B indicated when a resident is admitted they have a safety care plan developed.
-They had been monitoring resident 1 for safety since his admission.
*ADM A stated he had made it outdoors to the courtyard by himself "just the last few weeks".
-He liked to walk through the courtyard.
*They both stated they thought his 6/14/24 Elopement Risk Assessment had been coded correctly.

Review of the provider's 3/2019 Wandering and Elopements policy revealed, "The facility will identify residents who are at risk for unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents."

Review of the provider's 3/2022 Resident Assessments policy revealed, "All members of the care team, including licensed and unlicensed staff members, are asked to participate in the resident assessment process."