STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE	2200 13TH AVE , BELLE FOURCHE, South Dakota, 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
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 9/29/25. Areas surveyed included accident hazards related to hot beverages, fall prevention interventions, medication reordering, and trauma-informed care. Rolling Hills Healthcare was found not in compliance with the following requirements: F689, F699, and F755.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on a South Dakota Department of Health (SD) (DOH) facility-reported incident (FRI) review, interview, record review, and policy review, the provider failed to ensure staff implemented interventions for one of one sampled resident (1) identified with risk for burns from hot liquids, who subsequently sustained a burn from hot coffee. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: Her admission date was 4/15/25. The resident's Hot Liquid Safety Evaluation with an effective date of 9/8/25 indicated she required a cup with a lid or other adaptive cup and a clothing	F0689	Corrective Actions The DON reassessed Resident 1 for hot beverage risk and appropriate interventions. This assessment showed that she will still be allowed to use her own thermos with lid as long as hot beverages used come from facility kitchen or Bistro. If she refuses to use her thermos or it is not available, a facility mug with lid will be used. The care plan has been updated to include when she is served a hot beverage; a clothing protector will be offered each time. Identifications of Others Licensed nurses under the direction of the DON have completed hot beverage assessments on all current residents in the facility. Any resident that was found at risk now has interventions in place related to identified risk. A Master List of those residents who're at risk with appropriate interventions will be maintained. This list will be reviewed daily and updated as needed.	10-22-25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Herald Bose	Administrator	11-6-25

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F0689 SS = G	Continued from page 1 protector and/or lap protector when she drank hot liquids. Resident 1's 9/8/25 revised care plan revealed: "I am at risk for hot liquid spills, please ensure I use a cup with a lid and am sitting upright for all hot beverages". Her 9/10/25 Brief Interview for Mental Status (BIMS) assessment score was 14. That indicated she had no cognitive deficits. 2. Review of the provider's 9/10/25 FRI regarding resident 1 revealed: On 9/10/25, resident 1 had requested certified nurse aide (CNA) H to fill her personal Thermos cup with coffee. Neither the facility's bistro kitchen nor the primary kitchen had coffee available to serve. Cook E told CNA H there was coffee in the employee breakroom. He was not aware that CNA H would not have known to cool the breakroom coffee before she had poured it into resident 1's cup. The lid on the Thermos cup of coffee was tightened before CNA H handed the cup to resident 1. A short time later, resident 1 was heard calling out for help from her room. She stated that when the coffee in her cup reached her mouth, it was too hot. She expelled the coffee from her mouth onto her chest. Small blisters had formed on her upper chest where she had been burned. Resident 1 was not wearing a clothing protector at the time of the incident. The resident's medical provider was notified of the incident and ordered Lidocaine (a topical analgesic) to be applied to the resident's burn. The provider's post-incident interview with CNA H revealed she did not know there were temperature differences between the kitchen and bistro coffee and the breakroom coffee. Residents were not expected to be served coffee from the employee breakroom because the temperature of that coffee was not monitored. Through the provider's secure electronic messaging system, all staff were immediately reminded that residents were not to be served coffee from the employee breakroom. Additional staff education was provided during the provider's 9/12/25 Nursing Department Meeting. Hot beverage education was also added to the provider's new staff orientation checklist.	F0689	Systemic Changes All new residents will continue to have a hot beverage assessment completed upon admission. All residents will be reassessed at their quarterly assessments, annual assessment, significant change and with any incident. All residents at risk of hot beverage use will be reviewed by IDT, interventions and plans of care updated as appropriate, added to the facility digital whiteboard and added to master list. Facility completed Directed In-service Training. This included reviewing policies and procedures related to conducting and completing a safety assessment for hot beverages. Training for care planning hot beverage risks and how to consistently follow was completed. In addition, training on temping hot beverages, use of lidded cups, and clothing protectors and how this will be monitored was completed. All this training was reviewed, completed, and approved by the Administrator, DON, IDT, and medical director. This was done at a facility Ad Hoc QAPI meeting. All facility staff per department and responsibility will be Educated by the DON on the policy and procedures of serving hot liquids appropriately. This education included the newly approved policies and procedures for hot liquid consumption that include: temping, use of lids, and clothing protector use. Each department was educated to their specific role and responsibilities to the serving of hot liquids.	

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F0689 SS = G	Continued from page 2 Resident 1's care plan was updated after the above accident to include: any hot beverage served to resident 1 was expected to be served in a lidded cup. The use of her lidded Thermos remained appropriate. 3. Interview on 9/29/25 at 12:37 p.m. with cook E revealed resident 1 was currently using her lidded Thermos cup to drink coffee. If that cup was not available or if she preferred, her coffee was served in one of the kitchen's insulated coffee mugs. Those mugs had no fitted lids. Cook E stated that the kitchen did not maintain a list of residents who required specific accommodations, such as lids, when they were served hot beverages. 4. Interview on 9/29/25 at 1:35 p.m. with dietary manager D revealed that the kitchen had no coffee mugs with fitted lids for residents' use. 5. Interview on 9/29/25 at 2:00 with director of nursing (DON) B revealed that after resident 1's 9/10/25 burn, she had observed the resident between 9/11/25 and 9/16/25 to ensure her coffee was being served in a lidded mug. Those audits ended after 9/16/25. DON B had not seen resident 1 use anything other than her lidded Thermos cup to drink hot beverages. 6. Observation on 9/29/25 at 2:05 p.m. of resident 1 in her room with DON B and interview with resident 1 revealed the resident was lying in her bed. The resident's Thermos was not seen. Resident 1 did not know where her Thermos was or when she last saw it. Resident 1 stated that she sometimes used an unlidded coffee mug from the kitchen to drink her coffee from. Interview on 9/29/25 at 2:10 p.m. with DON B confirmed that neither the recommendations from resident 1's above Hot Liquid Safety Evaluation nor the intervention on her above care plan to ensure she used a cup with a lid for hot beverages were followed to mitigate resident 1's risk for burns from hot liquids. Review of the provider's Quarter 3, 2018 Safety of Hot Liquids policy revealed: "4. Once risk factors for injury from hot liquids are identified, appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include" "b. Serving hot beverages in	F0689	Dietary, Therapy, Activities, and Nursing staff have been educated on their specific roles in serving hot liquids including they will ensure lids are being used on all hot liquids served and that all residents are offered clothing protectors. All other departments have been instructed to defer to nursing and dietary for the serving of hot liquids. Monitoring The DON/designee will audit the dining room at mealtimes and during activities in which hot liquids are served. They will observe if clothing protectors are offered to residents at risk and hot beverages served in facility mugs have lids (Lids will be use to cover all hot liquids and all residents will be offered clothing protectors). The DON/designee will also conduct an audit of 10 residents at risk to ensure individual interventions are being done. These audits will include how beverages are being served in other areas such as the residents' room or common areas. Both audits will be done daily for two weeks and then weekly for three months. The DON/designee will report any identified trends or concerns to the Quality Assurance Committee monthly and as needed. If any adjustment to this system and audits needs to be made, this committee will take appropriate action.	

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F0689 SS = G	Continued from page 3 a cup with a lid;" Review of the providers' revised 5/16/25 Incidents and Accidents policy revealed: "Policy Explanation: The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care."	F0689		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on a South Dakota Department of Health (SD) (DOH) facility-reported incident (FRI) review, record review, interview, job description review, and policy review, the provider failed to implement comprehensive trauma-informed care for one of one sampled resident (1) with post-traumatic stress disorder (PTSD-a disorder in which an individual has difficulty recovering after experiencing or witnessing a traumatic event). Findings include: 1. Review of the provider's 9/10/25 FRI revealed resident 1 had requested certified nurse aide (CNA) H to fill her Thermos cup with coffee. Shortly after filling and returning that cup to the resident, the resident was heard calling out for help from her room. She stated that when the coffee reached her mouth, it was hot, and she expelled the coffee from her mouth onto her chest, resulting in a hot liquid burn. When director of nursing (DON) B spoke with resident 1 after the incident, the resident became upset. She told DON B that, as a child, her mother had burned her. The facility was aware that resident 1 had experienced childhood abuse, but did not know she was intentionally burned by a family member.	F0699	Corrective Action Social Services has re-assessed resident #1 to ensure all triggers and needed interventions to ensure comprehensive trauma informed care is being provided. Outside Therapy has been set up for this resident and social services have reached out to her former residence staff and therapist about her community DD plan. Social Services attempted to asked about any potential triggers or interventions that we may have missed and would be helpful. All of Social Services efforts have been documented and interventions have been updated in her plan of care. Identification of Others Social Services has completed an audit of all other residents to ensure comprehensive trauma informed care is provided. Any residents that were identified to have triggers and need further interventions, their care plans have been updated to their needs.	10-22-25

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F0699 SS = D	Continued from page 4 Resident 1 stated that the above burn incident had triggered her to have thoughts of harming herself. The resident's medical provider was updated, and resident 1 was transferred to a nearby hospital for evaluation related to those thoughts of self-harm. 2. Review of resident 1's electronic medical record (EMR) revealed she was admitted to the nursing home from a hospital on 4/15/25. Before the hospitalization above, the resident was a participant in a community-based service agency that served individuals with developmental disabilities (conditions that begin in childhood and result in physical, learning, language, and/or behavior impairments that last a lifetime) (DD). Her 4/15/25 hospital discharge summary and physician's orders had included the following diagnoses: DD, anxiety, major depressive disorder, post-traumatic stress disorder (PTSD), and a seizure disorder. A psychiatrist's name was beside "PTSD" on the problem list in that same report. Her 9/10/25 Brief Interview for Mental Status (BIMS) score was 14, which indicated her cognition was intact. Resident 1's 4/16/25 Trauma Assessment score was zero. A trauma screen was considered "positive" for scores of 14 or greater. Her 6/21/25 Trauma Assessment score was eight. It included that the resident felt upset and was bothered "a little bit" when something reminded her of a stressful experience from the past. She also had avoided activities or situations "a little bit" because they had reminded her of a stressful experience from the past. A 6/16/25 psychiatry progress note indicated that resident 1 wanted to speak with a therapist like the one she had talked to regularly at the community-based DD program. That same note stated resident 1 had past psychiatric hospitalizations and suicidal thoughts at times, but had not acted on them and did not have a plan to act on them. A trauma-informed care plan was not initiated for resident 1 until after her 9/10/25 burn incident. A 9/16/25 Social Services Designee (SSD) progress note indicated that resident 1 was seen by a counseling service on that day and was given different exercises	F0699	Systematic Changes Social Services will continue to assess all new residents at admission for comprehensive trauma informed care. Any residents that are identified to have triggers and needed interventions will be discussed in the morning clinical review meeting with the Interdisciplinary Team (IDT). Then appropriate Interventions will be included in their care plan. Facility Social Services staff and the IDT will be educated on the facilities policies and procedures of identifying and providing trauma Informed care. This will include their responsibility in providing this care to the residents. Monitoring The Social Services Director/designee will audit 10 current residents' care plans to ensure appropriate comprehensive trauma informed care is being done for those specific residents, and plans of care are reflective of needs. These audits will be done weekly for three months. The Social Services Director/designee will report any identified trends or concerns to the Quality Assurance Committee monthly and as needed. If any adjustment to this system and audits needs to be made, this committee will take appropriate action.	

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F0699 SS = D	Continued from page 5 to perform when she was anxious. 3. Interview on 9/29/25 at 3:00 p.m. with SSD G regarding resident 1's trauma-informed care revealed: She agreed that the above Trauma Assessments failed to identify the resident's trauma history, her developmental and functional history, her support network, or her strengths and coping mechanisms. SSD G stated that resident 1 had not shared much information with her regarding her trauma history. All SSD G had initially known about resident 1's PTSD was that the resident had experienced abuse by her parents in her childhood. SSD G agreed she should not have waited until resident 1's 9/10/25 burn incident to initiate resident 1's trauma-informed care plan. She felt, during the five months since the resident's admission, that the staff had gotten to know resident 1 better. Resident 1's individualized trauma information was appropriate to have included in a trauma-informed care plan and would have helped staff care for and interact with the resident to address her PTSD needs. SSD G confirmed she could have, but did not attempt to obtain psychiatric information regarding resident 1 from either the psychiatrist identified in the resident's 4/15/25 hospital discharge summary or the therapist referred to in the 6/16/25 psychiatry progress note. She did not request a copy of the resident's individual service plan that the DD agency had followed to manage the resident's PTSD and mental health concerns from resident 1's contact person, who was also the resident's caseworker at the DD program. SSD G had not followed up with the counselor referred to above, whom the resident 1 saw on 9/16/25, regarding the exercises the resident was encouraged to use when she was anxious. She agreed that those exercises may have been appropriate to have been carried over and implemented by the nursing home staff. SSD G felt that resident 1 would have no problem signing a release of information to allow SSD G to obtain records from the above individuals. Review of the provider's revised 6/16/25 Trauma Informed Care policy revealed: "2. The facility will use a multi-pronged approach to	F0699		

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F0699 SS = D	Continued from page 6 identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, an others." "4. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals to develop and implement individualized care plan interventions." "10. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident." Review of the provider's undated Social Services Director (SSD) job description revealed it was the responsibility of that SSD "to assure that the medically related emotional and social needs of the resident are met and maintained on an individual basis."	F0699		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F0755	Corrective Action The DON completed a chart review and assessment of Resident #1 and She had received the medications appropriately. She currently has all medications appropriately ordered, the correct diagnosis, all transcribed correctly, and they are available in the medication cart.	10-22-25

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F0755 SS = D	Continued from page 7 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on a South Dakota Department of Health (SD) (DOH) facility-reported incident (FRI) review, summary of investigation review, record review, interview, and policy review, the provider failed to ensure a resident's medication needs were met, which included ensuring: A physician-ordered PRN (as needed) medication for the treatment of prolonged seizure activity was available for administration to one of one sampled resident (1). A physician-ordered PRN medication was accurately transcribed in one of one sampled resident's (1) electronic medical record (EMR). Findings include: 1. Review of the provider's 8/5/25 FRI revealed: On 8/4/25, resident 1 fell out of her bed and onto the floor. The fall was not witnessed. “Staff heard the noise of the fall and responded by finding [resident 1] next to her bed. She continued to seize [a sudden burst of abnormal electrical activity in the brain that may include uncontrolled muscle movement and changes in a person's level of awareness] for many more seconds.” “[The] Nurse who discovered her [resident 1] called for support. [That nurse] Attempted to grab PRN [as needed] Diazepam nasal spray [a medication used to stop prolonged seizing] but it [that medication] was not present in [the medication] cart. This nurse grabbed PRN Ativan [an anti-anxiety medication that can be used to treat prolonged seizure activity] 0.5 mg [tablet] and administered it buccal [the space between the cheek	F0755	Identification of Others Licensed Nurses completed a check of all residents’ medication, and all residents have the appropriate medication ordered, with correct diagnosis, transcribed correctly, and available in the medication cart. Any issues found during this audit have been addressed and updated as needed. Systematic Changes The Facility completed Directed In-service Training. The Administrator, DON, IDT, Medical Director, and Pharmacy consultant reviewed and updated policies and procedures needed to ensure prescribed and necessary resident medications are available, and orders are accurately transcribed. This was completed during a facility Ad Hoc QAPI meeting. DON provided education to all licensed nurses and nurse management on the policies and procedures, including their responsibility for receipt of physician orders, accurately transcribing the orders for use, and ensuring medications are available for administration. Monitoring The DON/designee will audit 10 of the current residents’ medication orders to ensure all ordered medication is available, is accurate, has the appropriate diagnosis, and that the orders are transcribed correctly. These audits will be done weekly for 3 months	

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F0755 SS = D	Continued from page 8 and the teeth]. Within 10-15 seconds of buccal administration, [the] resident's seizure stopped and she began communicating with staff…" The facility had determined that the PRN Diazepam nasal spray was not available to administer to resident 1 because the pharmacy was waiting for the resident's medical provider to complete and return pre-authorization paperwork that was needed to order that medication. According to the facility's investigation, the facility staff contacted resident 1's medical provider and asked that either he promptly complete and return the pre-authorization paperwork or that the provider discontinue the order for the PRN Diazepam nasal spray. The facility's response to not having resident 1's PRN nasal spray available for administration was to ask the pharmacy to notify the facility staff anytime a medical provider failed to promptly complete and return the pre-authorization paperwork to the pharmacy. The facility would then follow up directly with that medical provider. 2. Review of resident 1's electronic medical record (EMR) revealed: A 6/18/25 physician's order: "Diazepam intranasal 10 mg, 1 spray in each nostril PRN for status epilepticus [prolonged seizure activity]." A 9/22/25 progress note completed by that same physician included the above PRN Diazepam nasal spray on resident 1's active medication list. Review of resident 1's July 2025 through September 2025 medication administration records (MAR) revealed: A 7/24/25 order for Ativan, 0.5 mg every 24 hours as needed (PRN) for anxiety, seizure disorder. On 9/10/25, that order was discontinued, and Ativan 0.5 mg every 24 hours as needed for anxiety was ordered. A seizure disorder was no longer identified as a clinical indication for administering resident 1's PRN Ativan. 3. Interview on 9/29/25 at 2:10 p.m. with certified medication aide (CMA) F revealed resident 1 did not have PRN Diazepam nasal spray available in the medication cart for administration if the resident had a prolonged seizure. 4. Interview on 9/29/25 at 2:20 p.m. with licensed	F0755	The DON/designee will report any identified trends or concerns to the Quality Assurance Committee monthly and as needed. If any adjustment to this system and audits needs to be made, this committee will take appropriate action.	

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ROLLING HILLS HEALTHCARE	2200 13TH AVE , BELLE FOURCHE, South Dakota, 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
F0755 SS = D	Continued from page 9 practical nurse (LPN) C regarding resident 1's PRN Diazepam nasal spray revealed that spray was ordered on 6/27/25 by the resident's medical provider, but the facility did not receive the medication. 5. Interview on 9/29/25 at 4:00 p.m. with DON B revealed resident 1's 9/10/25 PRN Ativan physician's order was incorrectly transcribed in resident 1's EMR to not include that it could be administered to resident 1 for prolonged seizures. DON B confirmed that without an available supply of resident 1's PRN Diazepam nasal spray or physician's orders to administer PRN Ativan for prolonged seizures, resident 1 had no medication to treat a prolonged seizure since 9/10/25. Resident 1 has had no prolonged seizure since that time. DON B stated she had sent a secure electronic message in mid-August 2025 to resident 1's medical provider. An order for an alternative seizure medication for resident 1 and the discontinuation of the PRN Diazepam nasal spray. She had not received any response to that request. DON B confirmed that resident 1's primary medical provider or other medical providers within that medical practice group were in the facility for resident visits no less than three times weekly. DON B did not speak face-to-face with any of those providers regarding an alternate seizure medication option for resident 1 and the discontinuation of the PRN Diazepam nasal spray. Review of the provider's revised 6/15/25 Medication Orders policy revealed: "3. Elements of the Medication Order:" [included] "j. Diagnosis or indication for use." "4. Documentation of Medication Orders:" [included] "b. Clarify the order." Review of the provider's revised 6/15/25 Medication Reordering policy revealed: "2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner." "5. In the event of new orders, the facility is allowed (24) hours to begin a medication unless otherwise specified by the physician."	F0755		