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 02/12/2026

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 recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/10/26 through 2/12/26. Rolling Hills Healthcare was found not in compliance with the following requirements: F554, F578, F655, F658, F686, F695, F727, F761, and F880.	F0000		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, manufacturer's recommendations for use, and policy review, the provider failed to ensure residents were evaluated for the ability to safely administer their medications or had a physicians order for two of two sampled residents (55 and 65) who were observed self-administering their medications and for 0ne of one sampled resident (62) observed with a medication left at her bedside by one of one certified medication aide (CMA) (M). Findings include: 1.Observation and interview on 2/10/26 at 1:45 p.m. with CMA K in resident 55's room revealed CMA K administered resident 55's nebulizer (a device that converts liquid medication it an inhalable mist) treatment. After placing the nebulizer medication inside the medication cup, CMA K attached the face mask to the medication cup and secured the nebulizer mask over resident 55's nose and mouth. CMA K started the nebulizer machine, and turned the machine on to start the treatment. CMA K stated she would return to the resident's room in 10 to 15 minutes when the treatment was completed which was CMA K's usual practice. Observation and interview on 2/10/25 at 2:40 p.m. with CMA K revealed she returned to resident 55's room to	F0554	Corrective Action Resident # 55 has been discharged from the facility. Resident #65 was assessed for self-administration of medication but was determined that she must be given direct instructions on how to take her medications. Resident #62 was assessed for self-administration but was determined that she cannot self-administrate her medications at this time. Identification of Others The DON/designee will conduct sweep of all residents to validate if resident has desire and ability to self-administer medication, and/or currently have medication at bedside, and complete SAMS assessment as appropriate,	3/17/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	3/16/2026

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F0554 SS = D	Continued from page 1 turn off the nebulizer machine, remove and clean the face mask. CMA K had "spaced it" [forgotten] and dd not return to resident 55's room 10-15 minutes after she had started the treatment. Review of resident 55's electronic medical record (EMR) revealed her Brief Interview for Mental Status (BIMS) assessment score was six. That indicated the resident had severe cognitive impairment. She had a medication self-administration assessment completed on 6/9/25. It indicated the resident was safe "for neb [nebulizer] self administer [self-administration] after [the nebulizer was] set up [by staff.] Staff will return to monitor usage and shut off [the] machine." There was no physician's order that indicated resident 55 was safe to self-administer her nebulizer treatment. 2. Observation on 2/11/26 at 8:00 a.m. of CMA L administering resident 65's inhaler revealed CMA L turned the base of the inhaler until it clicked, opened the inhaler cap and handed it to the resident. The resident shook the inhaler, placed her lips around the mouthpiece and dispensed one puff into her mouth. She opened her mouth after she took that puff, and the inhaled medication drifted out of her mouth. The resident self-administered the second puff from the inhaler in the same manner. Interview on 2/11/26 at 8:05 a.m. with CMA L regarding resident 65's inhaler self-administration revealed she knew the resident did not properly self-administer the inhaler. She thought the resident would have been able to correctly self-administer the inhaler with verbal instruction, but CMA L did not provide that instruction to the resident. Review of resident 65's EMR revealed she was admitted to the facility on 1/21/26. Her BIMS assessment score was 15. That indicated the resident's cognition was not impaired. She was not assessed to determine her ability to safely self-administer her inhaler. There was no physician's order that indicated the resident was safe to self-administer her inhaler. Review of the manufacturer's instructions for use of the Stiolto respimat inhaler revealed: "3. Exhale: Breath out fully, away from the inhaler.	F0554	All residents who are not determined to self-administer medications will take their medications with CMA or licensed nurse present. No medications will be left in the room or with the resident that have not been assessed and determined to be able to self-administer these medications. Systemic Changes The Director of Nursing/designee will provide training to nursing staff on medication use and residents' ability/rights to self-administer medication, the requirement to complete Self-Administration of Medication Evaluation if applicable (3/13/26). This education will include the importance of assuring medication is not left at bedside if resident has not been deemed appropriate for self-administration. Monitoring The DON/designee will conduct random audits of at least 10% of the population, to validate medications are not left at bedside unless resident deemed able to self-administer medications and that the SAMS assessments are completed for those able to self-administer medications. Audits to be completed 3x/week for one month, and then weekly 3 months. The DON/designee will report and discuss the audits including any identified concerns, or non-compliance trends to the Quality Assurance Committee monthly. As long as the audits are showing a 90% or higher compliance rate, we will continue these audits as planned. If compliance is below the QAPI committee will make appropriate adjustments.	

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F0554 SS = D	Continued from page 2 4. Inhale: Seal lips around the mouthpiece, avoiding covering the air vents. While taking a slow, deep breath, press the dose-release button. 5. Hold: Continue breathing in and hold breath 5-10 seconds." 3. Observation and interview on 2/11/26 at 11:40 a.m. with resident 62 while CMA L administered her medications revealed that on top of her over-the-bed table, there was a clear plastic cup with an amber colored liquid in it. The resident stated that the cup contained a "get well soon" medication. She was not able to remember who had given her that cup or how long the cup had been there. CMA L removed the cup from the resident's room after she administered the resident's medications. Interview on 2/11/26 at 11:45 a.m. with CMA L revealed she thought the liquid inside the cup removed from resident 62's room was Prostat, a physician-ordered nutritional supplement that was administered to the resident each morning. CMA L had administered the resident's scheduled Prostat earlier that morning. Review of resident 62's EMR revealed she was admitted to the facility on 1/13/26. Her BIMS assessment score was 11. That indicated resident 62 had moderate cognitive impairment. A medication self-administration assessment was not completed with the resident. There was a physician's order for one ounce of Prostat to be administered each morning to promote wound healing. That order did not indicate that the Prostat was able to be left at the resident's bedside. 4. Interview and EMR review on 2/11/26 at 10:00 a.m. and at 12:10 p.m. with assistant director of nursing (ADON) C revealed that resident 55's medication self-administration assessment was not current and was to be updated quarterly, but that did not occur. Resident 55 did not have a physician's order to self-administer her nebulizer treatment, but she should have. CMA K should not have left resident 55 unattended during her nebulizer administration. There was no medication self-administration assessment or a physician's order that supported resident 65's ability to self-administer her inhaler. She expected CMA L not have allowed resident 55 to self-administer	F0554		

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F0554 SS = D	Continued from page 3 her inhaler. Regarding resident 62's Prostat, ADON C had determined that on the morning of 2/10/26, CMA M had left resident 62's Prostat on her over-the-bed table without confirming if she was safe to self-administer that medication. There was no medication self-administration assessment or a physician's order that supported resident 62's ability to self-administer her Prostat. She expected CMA M to not have left resident 55's Prostat on her over-the-bed table without confirming she had consumed it. ADON C was responsible for ensuring medication self-administration assessments were completed for appropriate residents upon a resident's admission to the facility, quarterly, and with a significant change in the resident's condition. ADON C was responsible for ensuring there was a physician's order for a resident to self-administer a medication. 5. Review of the provider's revised 5/16/25 Resident Self-Administration of Medications policy revealed "A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely and has a provider order to do so." "4. A self-administration of medication assessment will be completed to determine if a resident is safe to self-administer medications prior to allowing them to do so." "16. A re-assessment for safety at a minimum should be considered by the interdisciplinary team for the following: a. Significant change in resident's status. b. Medication errors occur. c. Quarterly."	F0554		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to	F0578		

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F0578 SS = D	Continued from page 4 participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure a resident's advance directives (a legal document that expresses a person's health care wishes if they become unable to speak for themselves)/code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) was accurately documented for staff to implement the resident's chosen wishes for one of one sampled resident (20) with documented code status discrepancies.	F0578	Corrective Action Resident # 20 currently has advanced directives that match the family's wishes and physician orders (completed on 2/12/26). Social Services Staff have been educated by the administrator on these directives and how to follow them (3/10/26). Identification of Others The Social Services director has conducted a facility sweep on all residents to ensure that all residents currently have advanced directives and that there are no discrepancies between the resident/family wishes and the current Physician orders (3/12/26). Any discrepancies found were corrected prior to completing this sweep. Systematic Changes The Administrator provided education to Social Services Director and her assistant on how to obtain and maintain advance directives (3/10/26). Advance Directives will be obtained upon admission and reviewed at the quarterly assessment as well as whenever needed, such as a resident change in condition. A list of the residents advance directive wishes will be reviewed in Daily Clinical Meeting to be updated daily with any changes.	3/14/2026 3/17/2026

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F0578 SS = D	Continued from page 5 Findings include: 1. Review of resident 20's electronic medical record (EMR) revealed: *She was admitted to the facility on 2/5/20. *Her 2/5/26 Brief Interview for Mental Status (BIMS) assessment score was 7, which indicated her cognition was severely impaired. *There was a banner displayed in her EMR, which indicated that she did not want CPR (cardiopulmonary resuscitation, an emergency procedure to provide chest compression and often rescue breathing to preserve brain function and maintain blood circulation). *Her care plan had a 7/2/21 initiated advance directive focus area that indicated "I have a DNR [do not resuscitate] order." *There was a 7/23/21 physician's order for DNR. *Her signed 2/5/20 advance directive indicated that she wanted CPR/Full resuscitative measures. 2. Interview on 2/11/26 at 2:45 p.m. with social services director (SSD) R revealed: *She was responsible for obtaining the residents' advance directives when they were admitted to the facility, and advance directives were reviewed periodically during care conferences. *She acknowledged that resident 20's code status did not match her advance directive. *She acknowledged that resident 20 had a physician's order for DNR that did not match her advance directive for over four years. *She did not have an explanation for how this occurred. 3. Observation and interview on 2/12/26 at 12:18 p.m. with certified nursing assistant (CNA) T revealed: *There was a "cheat sheet" that listed all the residents in each hall. It had information about how to care for each resident, including the resident's code status, how they were able to transfer, their scheduled bath days, and which dining room they ate in.	F0578	Monitoring The Social Services Director/designee will conduct random audits of at least 10% of the population, to validate advance directives are in place, and there are no discrepancies from the resident/family wishes and the current physician orders. Audits to be completed weekly for one month, and then monthly for 3 months. The IDT will review in Daily Clinical meeting all residents have advance directives including all new admissions. The Social Services Director/designee will report and discuss audit findings for any Concerns or noncompliance identified to the Quality Assurance Committee monthly and as needed. As long as audit compliance is 90% or above, we will continue these audits as planned. If compliance is below the QAPI committee will make appropriate adjustments.	

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F0578 SS = D	Continued from page 6 -Resident 20 was listed as having a DNR code status on that sheet. *He stated there was another way to know a resident's code status, and that was by looking at the icons posted next to the residents' name plates outside of their room door. There would either be a heart icon (indicating a CPR code status) or a flower icon (indicating a DNR code status). -Resident 20 had a flower icon next to her nameplate. 4. Review of the provider's 6/15/25 Residents' Rights Regarding Treatment and Advance Directives policy revealed: *"On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive." *"Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to staff." *"During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes to any advance directives." *"Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions." *"Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care."	F0578		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and	F0655	Corrective Action Residents #3, #61, and #69 have had their current care plans reviewed with them or their representative (3/12/26). This has been documented.	3/17/2026

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F0655 SS = D	Continued from page 7 person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by:	F0655	Identification of Others The DON/designee completed Education with the IDT related to ensuring that all residents have had their current plan of care reviewed with them (3/12/26). All new resident admissions will have their baseline care plan completed and reviewed with them or the resident representative within 48 hours of admission. This review will be documented. Systematic Changes The IDT team and Licensed nurses will be re-educated by the DON on the policy and procedures for baseline care plans (3/12/26). This education will also include the expectation of making sure this policy and procedure is followed for all new admissions to the facility. In the facility morning clinical review meeting, the IDT will validate all new admissions have the baseline care plan completed within the first 48 hours of admission. Monitoring The DON/designee will conduct weekly audits of all new admissions that week, to validate if the baseline care plan was completed and reviewed with the new admission and/or the resident representative within 48 hours. Audits to be completed weekly for two months, and then monthly for 2 months.	

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F0655 SS = D	Continued from page 8 Based on record review, interview, and policy review, the provider failed to ensure the resident's baseline care plan was reviewed with the resident or the resident's representative within 48 hours of the resident's admission to the facility for three of six newly admitted sampled residents (3, 61, and 69). 1. Review of resident 3's electronic medical record (EMR) revealed: *He was admitted to the facility on 8/14/25. *His baseline care plan scanned into his EMR on 9/22/25 and was not dated or signed by the staff member who completed it. *There was no signature from resident 3 or their representative to indicate resident 3's baseline care plan was reviewed with them. 2. Review of resident 69's EMR revealed: *She was admitted to the facility on 1/30/26. *Her 1/30/26 baseline care plan signed by LPN/wound care nurse G. *There was no signature from resident 69 or their resident representative to indicate resident 69's baseline care plan was reviewed with them. 3. Interview on 2/11/2026 at 3:00 p.m. with ADON C revealed: *She had reviewed resident 3's and 69's care plans and there was no documentation that the residents' baseline care plans were reviewed with the resident or the resident's representative, that a copy was offered to them within 48 hours of admission to the facility. *She was not aware that documentation of the resident or resident's representative review of the baseline care plan or that they were offered a copy of it was required. 4. Review of resident 61's EMR revealed: *She was admitted to the facility on 1/16/26. *Her 1/16/26 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated her cognition was moderately cognitively impaired.	F0655	The DON/designee will report and discuss the audits including any identified concerns, or non-compliance trends to the Quality Assurance Committee monthly. As long as the audits are showing a 90% or higher compliance rate, we will continue these audits as planned. If compliance is below the QAPI committee will make appropriate adjustments.	

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F0655 SS = D	Continued from page 9 -There was no documentation that the baseline care plan was reviewed with the resident or the resident's representative, or that a copy was provided to them. -The staff member who completed the baseline care pan did not sign or date it. 5. Interview on 2/12/26 at 9:36 a.m. with ADON C revealed: *The facility's process for completing residents baseline care plan begins before the resident's admission to the facility which included an interdisciplinary team (IDT) meeting being conducted to review and discuss the admission huddle checklist (checklist that described what the resident needed or liked while being at the nursing home). *Once the resident arrived and was settled in their room, the admission nurse would meet with the resident and their family to review the admission huddle checklist. *When the baseline care plan was completed it waw placed in a binder located at the nurse's station. *When the physician conducted their initial assessment of the resident, the resident's baseline care plan was presented by the facility to the physician for review. 6. Review of the provider's 5/5/25 Baseline Care Plan policy revealed: *"The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care." "The baseline care plan will: a. Be developed within 48 hours of a resident's admission. *"A supervising nurse shall verify within 48 hours that a baseline care plan has been developed." *"A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand." *"A supervising nurse or MDS [Minimum Data Set]	F0655		

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F0655 SS = D	Continued from page 10 nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative." *"The person providing the written summary of the baseline care plan shall: a. Obtain a signature from the resident/representative to verify that the summary was provided. b. A copy of the summary will be maintained in the medical record." *"If the summary was provided via telephone, the nurse shall indicate the discussion, sign the summary document, and make a copy of the written summary before mailing the summary to the resident/representative."	F0655		
F0658 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 the staff followed nursing professional standards of practice for following physician's orders for insulin administration for one of one sampled resident's (67) who was administered according to the physician's order by one of one observed licensed practical nurse (LPN) (H). Findings include: 1. Observation and interview on 2/11/26 at 8:20 a.m. with LPN H in resident 67's room revealed she was checking the resident's blood sugar level. The amount of Novolog (insulin) she would administer to the resident was contingent upon the resident's blood sugar level. Resident 67's blood sugar level was 232. LPN H was not surprised that the number was a "little high" because the resident had "already eaten two breakfasts" that morning. 2. Interview and review of resident 67's medication	F0658	Corrective Action Resident # 67 was assessed at the time of this occurrence and provided needed care with no negative impact identified (2/11/26). Resident #67 has since been provided with proper insulin care according to the physician's orders. Identification of Others A sweep of all residents with insulin orders was completed to ensure no negative impact from pass administration of insulin (3/10/26). No negative impacts were identified. All residents who are prescribed with insulin orders will have the insulin provided to them according to the prescribed physician orders and the facility' s policies and procedures for insulin use. Systematic Changes All Licensed Nurses were reeducated by the DON/ADON on the policy and procedure for insulin use (3/11/26). This included following the physician's orders for when to use insulin for each resident.	3/17/2026

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F0658 SS = D	Continued from page 11 administration record (MAR) on 2/11/26 with LPN H revealed there was a 5/24/25 Novolog insulin physician order that indicated, based on the resident's blood sugar level of 232, that she was to receive three units of Novolog. The order also indicated that Novolog was to be administered before meals. LPN H acknowledged she did not follow the physician's order to administer resident 67's Novolog before the resident had eaten breakfast. LPN H knew that Novolog was a rapid-acting insulin (starts working within five to ten minutes of administration) and was used to improve blood sugar control, which was why it was ordered to be administered before meals. She stated it was difficult to ensure that morning blood sugar testing and insulin administrations for residents occurred at their scheduled times due to the number of residents who required morning blood sugar testing and insulin administration. 3. Interview on 2/11/26 at 5:00 p.m. with assistant director of nursing (ADON) C revealed she expected LPH H to administer resident 67's Novolog according to the physician's order, but that did not occur. Review of the provider's revised 5/7/25 Medication Administration policy revealed "10. Ensure that the six rights of medication administration are followed." Those rights included administering medication at the ""e. Right time."	F0658	Monitoring The DON/designee will conduct random audits of at least 25% of the residents that have insulin orders. The audit is F658to validate that the licensed nurse is administering insulin according to policy and procedures and the physician orders. Audits to be completed weekly for one month, and then monthly for 3 months. The DON/designee will report and discuss the audits including any identified concerns, or non-compliance trends to the Quality Assurance Committee monthly. As long as the audits are showing a 90% or higher compliance rate, we will continue these audits as planned.	
F0686 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 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:	F0686	Corrective Actions The Wound nurse on 2/11/26 obtained measurements of wound, wound characteristics and recorded them for Resident #3. An update was sent to the provider including wound description and current treatment. Per resident #3 request he is no longer on an air mattress as of 2/12/26. The Care Plan was updated for Resident # 3 to have staff to move his cushion from his wheelchair into the recliner when he desires to sit in the recliner. The ADON on 2/12/26 called the dialysis facility where resident #3 goes and ask them to provide a pressure reliving cushion when he is receiving dialysis treatments. They said they would provide this during his treatment.	3/17/2026

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F0686 SS = G	Continued from page 12 Based on observation, record review, interview, and policy review, the provider failed to identify, monitor, and implement pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) healing and prevention interventions for one of one sampled resident (3) who developed a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to his buttocks. Findings include: 1. Observation on 2/10/26 at 11:09 a.m. of resident 3 in his room revealed: *There was a cushion in his wheelchair seat. *He had an air mattress on his bed. *Resident 3 was sitting in his recliner. *There was no pressure relieving cushion in his recliner. 2. Review of resident 3's electronic medical record (EMR) revealed: *He was admitted to the facility from the hospital on 8/14/25. *His 11/21/25 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated his cognition was moderately impaired. *His diagnoses included diabetes (a condition involving disruptions in how the body regulates blood sugar), stage four kidney disease (severe kidney damage) with dependence on renal dialysis (blood is removed, cleaned by a machine, and returned to the body for people with kidney failure), and reduced mobility. *Resident 3's 8/14/25 discharge instructions from the hospital indicated, "Wound Care Instructions Wound location: Right buttock: -Cleanse area with mild soap and water. -Apply barrier cream 3-4 times daily and with each incontinence [involuntary urine or bowel leakage] episode. -Cover open areas with Oval Mepilex [a silicone foam wound dressing].	F0686	Identifications of Others The DON, ADON and the Wound Nurse completed a sweep of all residents to validate residents who need pressure relieving devices have them and they are working properly. The sweep also included residents with known skin alterations and obtained measurement, characteristics and recorded appropriately (2/27/26). The provider was notified as needed on the sweep findings. All residents with wounds are reviewed weekly at the nutrition and wound meeting and any needs identified are taken care of at that time. Systemic Changes The facility completed a Directed In-service Training which included a AdHoc QAPI meeting to review, revise as needed, and create policies and procedures for pressure ulcer prevention and management (3/9/26). The purpose of this meeting was to make sure we establish standards of care that identify and assess pressure ulcers so that proper documentation is accurate, and proper interventions are implemented. We further established standards of care for pressure ulcers including ongoing monitoring and assessing and processing wound care/treatment orders to ensure those orders are implemented as ordered. Following the meeting we educated all staff on their specific roles, responsibilities, and tasks related to pressure ulcer prevention, pressure ulcer management, and processing/following physician's orders (3/11/26).	

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F0686 SS = G	Continued from page 13 -May consider a silicone border dressing in place of the barrier cream as well due to the decrease in wound area. -Offload with repositioning every 2 hours and as needed. -Offload heels by suspending them off mattress with [a] pillow so heels float over [the] edge of [the] pillow. -Waffle cushion to chair and frequent repositioning while in the chair." *His undated baseline care plan (the admission personalized plan that addresses a resident's care needs, goals, and interventions) stated he had wounds on his sacrum (bone directly above the tailbone), left lateral (outside) foot, and the head of his penis. *Resident 3's 8/14/25 admission assessment indicated his skin was intact and his Braden Scale (a tool used to assess the risk of developing pressure ulcers) assessment score indicated he had high risk for developing a pressure ulcer. *Resident 3's 8/25/25 comprehensive care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had a focus area of "At risk of alterations in skin integrity" with interventions of "Provide incontinent care and apply moisture barrier to help protect skin prn [as needed]" and "Weekly skin assessment per facility policy." -It did not include that resident 3 had an open area to his right buttocks. -It did not include the application of barrier cream 3-4 times daily and with each incontinent episode, to offload with repositioning every 2 hours and as needed, and a waffle cushion to chair and frequent repositioning while in the chair as was indicated in resident 3's hospital discharge instructions. *His 12/22/25 skin assessment stated, "right buttock with small abrasion, barrier cream applied. Left buttock with 0.5 cm [centimeter] open area, erythematous [reddened] and bleeding scant amount. Area dressed with a 3 [inch] x3 [inch] Hydrocellular Foam Dressing Silicone Dressing with Border. Patient tolerated well. Notified [licensed practical nurse (LPN) /wound care nurse G]." *There were no skin assessments documented between	F0686	Staff were tested for their competencies and knowledge of the education provided. This education will be ongoing and monitored through our QAPI program. The DON/designee also completed education for Licensed nurses on their responsibility for the process of ensuring pressure reducing devices are checked to ensure they are working properly (3/16/26). Monitoring The DON or designee will conduct wound audit for 10% of the population. These audits will occur five times per week for one month, starting on 3/13/26. If no concerns are identified, monitoring will be reduced to three times per week for one month, then weekly for one month, and then quarterly. Monitoring will include review of compliance and accuracy of weekly skin checks including measurements and characteristics. These audits will also include monitoring the wound care provided, pressure relieving devices are in place and working properly, notifications for any changes in wound care, and Nutrition and Wound Committee recommendations are being implemented. The DON/designee will report and discuss the audits including any identified concerns, or non-compliance trends to the Quality Assurance Committee monthly. As long as the audits are showing a 90% or higher compliance rate, we will continue these audits as planned. If compliance is below the QAPI committee will make appropriate adjustments.	

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F0686 SS = G	Continued from page 14 12/22/25 and 1/1/26. *Resident 3's 1/1/26 skin assessment indicated his left buttock had an facility acquired open wound and his right buttock had an facility acquired abrasion. The wounds were "Stable: previously deteriorating wound characteristics plateaued. -There were no measurements or a description of those facility acquired wounds. *There was no skin assessment documented on 1/8/26. *Resident 3's 1/15/26 skin assessment indicated his left buttock had a facility acquired open wound and his right buttock had a facility acquired abrasion. The wounds were "Improving; overall wound characteristics improved." -There were no measurements or a description of those facility acquired wounds. *Resident 3's 1/22/26 skin assessment indicated his left buttock had a facility acquired open wound and his right buttock had a facility acquired abrasion. -There were no measurements or a description of those facility acquired wounds or whether his wounds were improving, worsening, or remaining stable. *Resident 3's 1/29/26 skin assessment indicated his left buttock a facility acquired open wound and his right buttock had a facility acquired abrasion. -There were no measurements or a description of those facility acquired wounds or whether his wounds were improving, worsening, or remaining stable. *There was no skin assessment documented on 2/5/26. *Resident 3 had a 2/5/26 physician's order for, "Rt [right] and Lf [left] buttock apply triad [a zinc-based paste to manage draining wounds such as a pressure ulcer] daily with sactal [sacral] foam dressing [a specially formed dressing to be for the sacrum] applied till [until] healed every day shift". *His 2/10/26 care plan indicated he had a focus area that was initiated on 12/23/25 for wound management with interventions of "Evaluate ulcer characteristics", "Measure ulcer on at regular intervals", "Monitor ulcer for signs of infection", "Monitor ulcer for signs of progression or declination", and "Notify provider if no signs of improvement on current wound regimen".	F0686		

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F0686 SS = G	Continued from page 15 3. Interview on 2/11/26 at 3:20 p.m. with assistant director of nursing (ADON) C revealed: *There were no measurements or descriptions of resident 3's wounds on his buttocks because they were not considered pressure ulcers, and LPN/wound care nurse G had not seen him during her weekly rounds. *A cushion was placed in his wheelchair on 11/3/25 because he was sliding down in his wheelchair. *His physician was notified of the newly identified wound on his buttock on 12/23/25 at 11:03 a.m. -The notification stated, "Resident has abrasion to his RT. and LT buttock due to sliding in W/C [wheelchair]". *His air mattress was placed on his bed on 1/27/26 (after the wounds were identified). 4. Observation and interview on 2/12/26 at 8:23 a.m. with resident 3 in his room revealed: *He did not know when the cushion was placed on the seat of his wheelchair and he could not recall having a pressure reduction cushion on his recliner. *He was sleeping in his recliner for about the last month because the air mattress on his bed "leaked". *When he would sleep on the air mattress it would deflate, and he would end up lying on the frame of the bed. *The air mattress was unplugged at the time of this observation. 5. Interview on 2/12/26 at 9:34 a.m. with certified nursing assistant (CNA) O revealed: *She did not know if resident 3 slept in his recliner or bed, but each day when she arrived to work he was dressed and sitting in his recliner or wheelchair. *She did not unplug resident 3's air mattress. *She did not know when the cushion was placed in resident 3's wheelchair. *She acknowledged there was no pressure reduction cushion in resident 3's recliner. *Resident 3's buttocks did not have a wound dressing	F0686		

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F0686 SS = G	Continued from page 16 when she assisted him to the bathroom that morning (2/12/26) but stated "some days" there was a dressing on his buttocks. *She applied barrier cream to his buttocks each time she changed his brief or assisted him to the toilet because he was incontinent. 6. Observation and interview on 2/12/26 at 9:43 a.m. with LPN/wound care nurse G and CNA O during resident 3's skin assessment revealed: *There was no wound dressing on resident 3's buttocks. *He had a six cm by three and one-half cm area on his right buttocks where the first layer of skin was missing and the top of that area had a two cm by three and one-half cm scabbed area. His left buttocks had a three and seven-tenths cm by two cm area where his first layer of skin was missing. *LPN/wound care nurse G stated she did not consider resident 3's wounds on his buttocks pressure ulcers because the skin blanched (the skin turned white when pressure was applied and then returned to pink after the pressure was released). *LPN/wound care nurse O did not apply a dressing to resident 3's buttocks. She rolled him back onto his back, and asked CNA O to assist him out of bed and back into his chair. *LPN/wound nurse care G stated she had worked as an LPN for one year and had completed additional training to be a wound care nurse on 10/13/25. *LPN/wound care nurse G did not have a designated registered nurse (RN) who oversaw her wound care role, but she would ask an RN if she had any questions related to a wound. *She monitored surgical wounds, vascular wounds, arterial wounds, and pressure ulcers for residents. *The nurse assigned resident 3 on his bath day was to perform his weekly skin checks and document in his EMR the measurements and descriptions of his wounds. *She acknowledged that resident 3's wounds were not measured or described on his weekly skin assessments. *LPN/wound care nurse G had completed resident 3's admission assessment on 8/14/25.	F0686		

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F0686 SS = G	Continued from page 17 *Within the admission assessment LPN /wound care nurse G had completed a skin assessment and documented that resident 3 did not have skin concerns. *She was not aware that resident 3's baseline care plan indicated he had wounds on his sacrum, left foot, and the head of his penis. *She did not complete resident 3's baseline care plan and did not know who had completed it. *LPN/wound care nurse G acknowledged that the location on resident 3's buttocks was an area that sustained pressure when he was sitting in his recliner and wheelchair. *She was not aware that resident 3 was sleeping in his recliner without pressure reduction cushion. 7. Interview and EMR review on 2/12/26 at 11:00 a.m. with RN N revealed: *If a pressure ulcer was identified on a resident, the nurse should document the size and a description of the ulcer in a skin assessment in that resident's EMR and then notify the LPN/wound care nurse G and the physician. *A risk management form was to be completed by the nurse who identified the ulcer to notify management that a pressure ulcer was identified on a resident. *RN N would measure and document a resident's pressure ulcer in a skin assessment in that resident's EMR when it was initially identified or if she thought the pressure ulcer was increasing in size or getting worse. *LPN/wound care nurse G measured and documented the resident's pressure ulcers weekly in a skin assessment. *RN N had completed resident 3's wound care treatment to his buttocks that morning (2/12/26). *She did not put a dressing on his buttocks because the physician's order was for triad paste to his buttocks. *Upon review of resident 3's treatment order for his buttocks she verified the physician's order for resident 3's wound care treatment on his buttocks was to use triad paste and cover it with a foam dressing. -She stated she did not apply the foam dressing over the triad paste because the previous order did not have that on it, and she did not read the entire order	F0686		

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F0686 SS = G	Continued from page 18 before she completed his treatment that day. *RN N stated resident 3 had an ongoing issue with skin breakdown on his buttocks. *When asked what her assessment of resident 3's buttocks wound was that morning she stated he had a stage II pressure ulcer. *He was not sleeping in his bed for at least the past week. There was one night he slept in his wheelchair all night, so an air mattress was placed on his bed. She thought after that he was sleeping in his bed because the night shift nurses did not report anything different. *When she arrived at the facility to work her morning shift, he was in his wheelchair or recliner ready to go to dialysis. 8. Interview on 2/12/26 at 12:11 p.m. with ADON C revealed: *ADON C was an LPN. *The CNAs were to observe each resident's skin daily and report any abnormalities to the nurse. *The nurse was to check the resident's skin and document their observation in the resident's EMR weekly on their scheduled bath day. *If the nurse observed a wound on a resident's, ADON C expected the nurse to measure the wound and then document it in the resident's EMR with a description of the wound, such as drainage and what the wound bed looked like. The nurse would then notify the resident's primary care provider. *The nurse who identified the wound was to notify LPN/ wound care nurse G to assess the resident's wound. *If LPN/wound care nurse G determined the wound was not a pressure ulcer, venous ulcer, arterial ulcer, or surgical wound she would refer the wound back to the nurses to manage the assessments and treatments of that wound. *The nurses would then be responsible for completing an "alert" progress note in the resident's EMR related to that wound two times a day until the wound was healed to track the progress of the wound. -ADON C acknowledged that there were no "alert"	F0686		

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F0686 SS = G	Continued from page 19 progress notes in resident 3's EMR related to his 12/22/25 wounds. *If the nurses felt a resident's wound had increased in size or worsened ADON C expected the nurses to notify LPN/wound care nurse G so she could reevaluate the wound. -ADON C stated there was no documentation that the nurses had notified LPN/wound care nurse G that there was an increase in the size of resident 3's wounds on his buttocks. *She expected the nurses to follow the physician's orders for the treatment of a wound. *Residents with pressure ulcers were reviewed during the provider's weekly nutrition and wound committee meetings (an interdisciplinary team meeting to discuss residents who had nutritional risks or had wounds, and to discuss possible interventions for those nutritional risks or wounds). -Resident 3 was not reviewed related to his wounds on his buttocks because they were not identified as pressure ulcers, but he was reviewed because he received dialysis. *Resident 3 had a cushion in his wheelchair before his wounds on his buttocks were identified on 12/22/25. *There was no documentation to support resident 3 having a pressure reduction cushion in his recliner. *His air mattress was placed on his bed after resident's 3's wounds on his buttocks were identified on 12/22/25 because he had stated his other mattress was too hard. *ADON C stated resident 3 had told her he did not use a cushion in his dialysis chair, which he sat in for several hours at a time three days a week, but she did not confirm that with the dialysis staff. *She acknowledged that resident 3's 8/14/25 hospital discharge instructions indicated that resident 3 had a wound on his right buttocks with orders to clean and apply a dressing over the wound, apply barrier cream, place a waffle cushion in resident 3's chair and to reposition him frequently while he was in the chair. *She acknowledged resident 3's undated baseline care plan indicated he had wounds on his sacrum, left foot, and the head of his penis but his 8/14/25 admission	F0686		

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F0686 SS = G	Continued from page 20 assessment indicated he did not have any wounds. *She acknowledged there were missing weekly skin checks in resident 3's EMR. *She acknowledged that it could not be determined if resident 3's wounds to his left and right buttocks were improving or worsening, because there were no weekly measurements or descriptions of his wounds. *She acknowledged that resident 3's care plan did not contain pressure reduction measures such as his wheelchair cushion, air mattress, or other preventative pressure reduction measures. 9. The director of nursing (DON) was not in the facility or available for interview during the survey. 10. Review of the provider's 6/9/25 Pressure Injury Prevention and Management policy revealed: *"The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate." *"Examples of risk factors [for pressure injury risk] include, but are not limited to:" -"Impaired/decreased mobility and decreased functional ability:" -"Co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus;" -"Drugs such as steroids that may affect healing;" -"Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency;" -"Resident refusal of some aspects of care and treatment;" -"Resident refusal of some aspects of care and treatment;" -"Cognitive impairment;" -"Exposure of skin to urinary and fecal incontinence;" -"Under nutrition, malnutrition, and hydration	F0686		

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F0686 SS = G	Continued from page 21 deficits; and" -"The presence of a previously healed pressure injury." *"Evidence-based interventions for prevention [of pressure ulcers] will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions include, but are not limited to:" -"Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc);" -"Minimize exposure to moisture and keep skin clean, especially of fecal contamination;" -"Provide appropriate, pressure-redistributing, support surfaces;" -"Provide non-irritating surfaces; and" -"Maintain or improve nutrition and hydration status, where feasible." *"Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate (if present), presence of pain, signs of infection, wound bed, wound edge and surrounding tissue characteristics." *"Nurse Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance and document a summary as applicable." *"Nurse Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance and document a summary as applicable." -"The presence of a new pressure injury upon identification." -"The progression towards healing, or lack of healing, of any pressure injuries." Review of the provider's 6/10/25 Skin Assessment policy revealed: *"A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter." *"Documentation of skin assessment:"	F0686		

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F0686 SS = G	Continued from page 22 -"Include date and time of the assessment, your name, and position title." -"Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.)" -"Document wound." -"Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain)." -"Document if resident refused assessment and why." -"Document other information as indicated or appropriate."	F0686		
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure infection control practices were followed regarding the storage of oxygen equipment for four of four sampled residents (1,18, 49, and 69) who required the use of oxygen. Findings included: Observation and interview on 2/10/26 at 10:02 a.m. with resident 1 in his room revealed: *He was lying in bed with his nasal cannula on which was connected to his oxygen concentrator (a device that filter room air into purified oxygen) beside him. *His wheelchair was positioned next to his bed and had a portable oxygen tank hanging on the back. There waws a nasal cannula connected to the oxygen tank that was laying on the floor underneath the wheel of the wheelchair.	F0695	Corrective Action Residents # 1, #18, #49, and 69 were checked, and the oxygen storage issues were all fixed on the day these issues were identified (2/12/26). Identification of Others A sweep of all residents with oxygen needs will be completed to validate their oxygen equipment is stored in an appropriate way that helps prevent infections (3/9/26). Any issues found will be fixed at the time of the sweep. Systematic Changes Central Supply ensures that bags are available for proper storage of oxygen tubing that will be used when the tubing is not in use. All staff have been educated by the DON/ADON on proper storage of oxygen equipment including tubing to prevent infections according to their own roles (3/11/26).	3/17/2026

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F0695 SS = E	Continued from page 23 *The resident stated that the staff assisted him with removing and reapplying his nasal cannula. 2. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted to the facility on 10/29/25. *His 12/15/25 Brief Interview of Mental Status (BIMS) assessment score was 12, which indicated his cognition was moderately impaired. *His diagnoses included chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia (where tissues are deprived of adequate oxygen), adult failure to thrive, hypotension (low blood pressure), cachexia (irreversible metabolic syndrome, severe loss of skeletal muscle mass and body fat, resulting in extreme weakness), and ischemia cardiomyopathy (the heart muscles become weakened and cannot pump blood efficiently). *He had a 1/16/26 physician's order, "Oxygen: Oxygen at 1-5 L [liter] per NC [nasal canula] every shift for oxygen use." 3. Observation on 2/10/26 at 10:15 a.m. of resident 18's room revealed: *Resident 18 was lying in bed with a nasal cannula on that was attached to her oxygen concentrator. *On the back of resident 18's wheelchair was a portable oxygen tank. *Attached to the portable oxygen tank was a nasal cannula that was draped over the back of the wheelchair and lying on resident 18's wheelchair seat that had dry white flakes on the cushion. 4. Observation on 2/10/26 at 10:20 a.m. of resident 69's room revealed: *Resident 69 was not in her room. *There was an oxygen concentrator (a device that filters room air into purified oxygen) by the wall with a nasal cannula coiled up and placed under the handle of the oxygen concentrator. 5. Observation on 2/10/26 at 2:04 p.m. of resident 69's room revealed:	F0695	DON/designee will ensure that oxygen tubing is changed weekly and make sure storage bags are always available for tubing when not in use. Nursing Staff was educated by the DON/ADON where to find storage bags and tubing when needed. Monitoring The DON/designee will conduct random audits of at least 25% of the residents that have oxygen orders, to validate that oxygen equipment including oxygen tubing is being stored properly when not in use. Audits to be completed 3x/week for one month, and then weekly 3 months. The DON/designee will report and discuss the audits including any identified concerns, or non-compliance trends to the Quality Assurance Committee monthly. As long as the audits are showing a 90% or higher compliance rate, we will continue these audits as planned. If compliance is below the QAPI committee will make appropriate adjustments.	

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F0695 SS = E	Continued from page 24 *She was lying in bed wearing a nasal cannula that was attached to her oxygen concentrator. *The nasal cannula attached to her portable oxygen tank on the back of her wheelchair was hanging on the handle of resident 69's wheelchair. *The portion of the nasal cannula that would be put into resident 69's nose was in touching the handle of the wheelchair where someone's hands would be placed to push the wheelchair. 6. Observation on 2/10/26 at 2:50 p.m. in resident 49's room revealed: *He was sitting in his recliner with his feet elevated. *His wheelchair was next to his bed, and it had a portable oxygen tank on the back of it. *The nasal cannula attached to the portable tank was draped over the back of the wheelchair and rested on the wheel of the wheelchair. 7. Observation on 2/10/26 at 4:45 p.m. of resident 18's room revealed: *Resident 18 was not in her room. *Her oxygen concentrator was on, and the attached nasal cannula was draped over the head of resident 18's unmade bed. 8. Observation on 2/11/25 at 3:27 p.m. of resident 18's room revealed: *Resident 18 was not in her room. *Her oxygen concentrator was on, and the attached nasal cannula was hanging on the siderail (bar/bars attached to the bed) attached to the head of her bed and the prongs that are placed in thar resident's nose were lying against the base of the side rail and mattress. 9. Interview on 2/11/26 at 2:01 p.m. with certified nursing assistant (CNA) O revealed: *Resident 18 required staff assistance to switch between using her oxygen concentrator in her room and her portable oxygen tank on her wheelchair.	F0695		

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F0695 SS = E	Continued from page 25 *Resident 69 required staff assistance to switch between using her oxygen concentrator in her room and her portable oxygen tank on her wheelchair. *Nasal cannulas were to be stored in plastic bags and attached to the oxygen concentrator or portable oxygen tank when they were not being used by the residents. *She acknowledged that the residents' nasal cannulas were not stored in plastic bags on 2/10/26 because there were no plastic bags on the residents' oxygen concentrators or portable oxygen tanks. She tried to store them in places where they were not at risk of touching the floor. *She had asked for plastic bags to hang on the residents' oxygen concentrators and portable oxygen tanks on 2/10/26, but the plastic bags were not brought to her from supply. 10. Observation on 2/12/26 at 9:36 a.m. in resident 49's room revealed: *He was not in his room. *There was an oxygen concentrator in his room with a nasal canula connected to it, and the nasal canula was lying on the floor. 11. The director of nursing (DON) was not in the building and was not available for interview. 12. Interview on 2/12/26 at 9:41 a.m. with assistant director of nursing (ADON) C revealed: *When a resident was admitted to the facility and required oxygen the admitting nurse was responsible for obtaining a storage bag and placing the resident's nasal cannula in the bag. *The staff were expected to use the bag to store the nasal cannula when it was not in use. *If the residents did not have a storage bag, the staff were responsible for obtaining one for the residents. 13. Review of the provider's 5/16/25 Oxygen Administration policy revealed: *"Change oxygen tubing and mask/cannula weekly and as	F0695		

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F0695 SS = E	Continued from page 26 needed if it becomes soiled or contaminated." *"Keep delivery devices covered in a plastic bag when not in use."	F0695		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(b)(4)(C)(i);483.35(c)(1)-(3) Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on Payroll Based Journal (PBJ) reports, interview, schedule review, and facility assessment review, the provider failed to ensure a registered nurse (RN) was scheduled for eight consecutive hours of coverage for six days in quarter four (July 1 through September 30) of fiscal year 2025 and for two of	F0727	Corrective Action The facility will ensure at least 8 hours of RN will be scheduled every day. Identification of Others This citation has the potential of effecting all residents, so at least 8 hours of RN coverage will be scheduled every day to provide the minimum coverage needed. Systematic Changes Facility management staff including the scheduler have been educated on the requirement to have at least 8 hours of RN coverage every day (3/10/26). The facility scheduler will ensure that RNs will be scheduled at least 8 hours daily. The facility will use the necessary means to ensure there is RN coverage as needed. This will include DON/designee will be informed if the scheduled RN call off or can't make the scheduled hours. The DON/designee with the scheduler will utilize on call staff to cover RN hours as needed. Monitoring The Administrator/designee will conduct a review 5x a week for 4 weeks, then weekly to validate that the RN coverage has been sufficient to meet minimum requirements of 8 consecutive hours 7 days a week.	3/17/2026

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F0727 SS = F	Continued from page 27 fourteen days (1/29/26 and 1/31/26) between 1/28/26 and 2/10/26. Findings include: 1. Review of the PBJ report for quarter 4 of fiscal year 2025 revealed the provider did not have RN coverage for eight consecutive hours on 7/4/25, 7/19/25, 7/26/25, 7/27/25, 8/30/25, and 8/31/25. 2. Interview on 2/10/326 at 8:30 a.m. with administrator A during the entrance conference revealed the provider did not have any nurse staffing waivers. 3. Interview on 2/12/26 at 8:37 a.m. with administrator A revealed there were not eight consecutive hours of RN coverage on 7/4/25, 7/19/25, 7/26/25, and 7/27/25. *An RN had not been scheduled to work on 7/4/25, 7/19/25, 7/26/25, and 7/27/25. 4. Interview on 2/12/26 at 10:51 a.m. with assistant director of nursing (ADON) C revealed: *There were not eight consecutive hours of RN coverage on 8/30/25 and 8/31/25. *An RN had not been scheduled to work on 8/30/25 and 8/31/25. *Recently the provider had made the daily eight consecutive hours of RN coverage a focus area for the facility and two RNs were hired to help cover those hours on 12/8/25 and 2/3/26. 5. Review of the nursing schedule from 1/28/26 through 2/11/26 revealed: *On 1/29/26 RN U was scheduled from 8:30 a.m. until 11:30 a.m. and director of nursing (DON) B was scheduled 2:00 p.m. until 7:00 p.m. -These hours did not satisfy the requirement of eight consecutive hours of RN coverage. *On 1/31/26 DON B was scheduled from 9:00 a.m. until 1:00 p.m. -These hours did not satisfy the requirement of eight consecutive hours of RN coverage. 6. The director of nursing (DON) was not in the facility or available for an interview during the	F0727	The Administrator/designee will report and discuss the audits including any identified concerns, or non-compliance trends to the Quality Assurance Committee monthly. As long as the audits are showing a 100% compliance rate, we will continue these audits as planned. If compliance is below the QAPI committee will make appropriate adjustments.	

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F0727 SS = F	Continued from page 28 survey. 7. Review of the provider's 9/22/25 Facility Assessment Tool revealed "2-6 floor direct care RN/LPN [licensed practical nurse] per day (at least 1 RN daily, may include MDS [Minimum Data Set] for RN needs, and nurses working on medication carts)".	F0727		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the resident's medications were labeled and discarded for: Two of two sampled residents (7 and 18) who had opened boxes of nasal spray (Flonase) which that were not kept available for use after their use-by date. Two of two sampled residents (18 and 62) whose pain medications (hydrocodone and oxycodone) were not labeled according to their physician's order. One of one sampled resident's (15) inhaler that was expired and was not stored in a secure location. Findings include:	F0761	Corrective Action: Residents #7, #18, and #62 on the date it was identified had their medications reviewed and fixed so that there was no medication that was not matching the physician's orders, and that was not used after the expiration dates (2/12/26). Resident # 15 had the inhaler removed from her room upon the facility being notified. Her room was also checked, and no other medications were found to be unsecured in her room (2/12/26). Identifications of Others: A sweep of all resident rooms was done to ensure there were no unsecured medications in any resident room (3/9/26). The DON/designee also audited all medications to ensure that they are labeled as ordered and that they are not being used past the expiration dates (3/9/26). Any issues found during the sweeps were fixed at that time. Systemic Changes: The DON/designee provided education to all Licensed nurses and CMAs to make sure they follow policies and procedures for medication administration specifically making sure the medication being passed is according to the physician orders, Orders match the medication and is not administered passed the expiration date (3/13/26).	3/17/2026

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F0761 SS = E	Continued from page 29 1. Observation and interview on 2/10/26 at 10:15 a.m. of the 400 hall medication cart with certified medication aide (CMA) K revealed: *There were two opened boxes of residents' Flonase nasal sprays. *Resident 7's nasal spray had a use-by date of 6/25/25, and resident 18's nasal spray had a use-by date of 12/29/25. *CMA K stated that nasal sprays were labeled with use-by dates, and the staff were expected to review those dates before administering the spray. Those expired nasal sprays should have been discarded by the staff. *Review of residents 7 and 18's medication administration records (MAR) revealed both residents had orders for PRN (as needed) Flonase. 2. Observation, interview and medication administration record (MAR) review on 2/10/26 at 12:10 p.m. with CMA K who was preparing resident 18's medications for administration revealed: *The resident's hydrocodone blister pack (a hand-held card from which individual pills or capsules are dispensed into medication cups for administration) label indicated one pill was to be administered every four hours PRN. *The resident's MAR indicated one pill was administered four times daily. CMA K then administered one hydrocodone pill to the resident. *CMA K knew she was expected to compare the resident's blister pack label to the resident's MAR order for any discrepancies between the two before she administered the hydrocodone pill. She did not do that. 3. Observation, interview and MAR review on 2/11/26 at 11:40 a.m. with CMA L who was preparing resident 62's medications for administration revealed: *The resident's oxycodone blister pack label indicated one 5 mg (milligram) pill was to be administered three times daily and another 5 mg pill was to be administered one time daily PRN. *The resident's MAR indicated that one 5 mg oxycodone pill was administered four times daily. There was a second, separate order on that MAR for one 5 mg pill to	F0761	All Nursing staff was educated on ensuring that medication is not left unsecured. If a medication is found unsecured, it will be reported and removed to a secure location immediately (3/13/26). Monitoring/QAPI: The DON/designee will conduct a medication review weekly for 4 weeks, then monthly for 3 months to validate medications are ordered according to physician orders and that they are not past the expiration dates. The audits will also include monitoring license nurses and CMAs for any deficient practice and reviewing the med carts for outdated medications. Any deficient practice identified will be fixed at that time. The DON/designee will report and discuss the audits including any identified concerns, or non-compliance trends to the Quality Assurance Committee monthly. As long as the audits are showing a 90% or higher compliance rate, we will continue these audits as planned.	

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F0761 SS = E	Continued from page 30 be administered one time daily PRN. *CMA L recognized the discrepancy between the resident's blister pack label and the resident's MAR order. She knew the resident's MAR was updated on 1/30/26 to reflect four scheduled oxycodone administrations (8:00 a.m., noon, 4:00 p.m., and 8:00 p.m.). She thought there should have been a "change order" sticker affixed to the resident's blister pack to alert staff to the updated oxycodone order. 4. Interview on 2/11/26 at 4:45 p.m. with assistant director of nursing (ADON) C regarding medication labeling revealed: *That a resident's blister pack label was expected to be compared to their MAR for any discrepancy by the staff before administering that medication. Any discrepancy was expected to be brought to her attention or to another licensed nurse for follow-up. *The licensed nurse was responsible for affixing any change order stickers to the blister pack based on order changes and for notifying the pharmacy of the blister pack label discrepancy. 5. Review of the provider's revised 5/7/25 Medication Administration policy revealed: "11. Review MAR to identify medication to be administered." "12. Compare medication source (bubble [blister] pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, routine, and time." There was no indication of what process to follow if a discrepancy was found between the medication source and the MAR. Review of the provider's revised 5/16/25 Labeling of Medications and Biologicals policy revealed "12. The pharmacy must be informed of any order changes or changes in directions for the use of the medication." 6. Observation on 2/10/26 at 10:55 a.m. of resident 16's room revealed he had an inhaler lying on his bedside table. 7. Observation and interview on 2/11/26 at 8:31 a.m. with resident 16 in his room revealed: *The inhaler on his bedside table was albuterol (a medication used to treat shortness of breath or	F0761		

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F0761 SS = E	Continued from page 31 wheezing) 90 mcg (micrograms) per inhalation. -It expired on 6/30/23. *Resident 16 stated he did not use an inhaler but his roommate resident 15 did. *He did not know if resident 15 had recently used that inhaler. *He stated a nurse had brought the inhaler into his room, set it on his bedside table, and then left the room and never came back to get it. 8. Review of resident 16's EMR revealed he did not have a physician's order for an inhaler or for the self-administration of medications. 9. Review of resident 15's EMR revealed: *She was admitted to the facility on 9/18/25. *Her 1/28/26 BIMS assessment score was 8, which indicated her cognition was moderately impaired. *She had a 9/18/25 physician's order for "Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT [micrograms per actuation (per puff)] 4 puff inhale orally every 4 hours as needed" for wheezing. *She did not have a physician's order to have medications stored at her bedside. 10. Interview on 2/11/26 at 11:09 a.m. with resident 15 revealed she did not know if she had used the inhaler that was on resident 16's bedside table. 11. Interview on 2/11/26 at 2:10 p.m. with CMA K revealed: *She was not aware there was an inhaler on resident 16's bedside table. *He did not have a physician's order for an inhaler but his roommate resident 15 did. *She stated that there should not be any medications stored in that room. *If she had seen the inhaler she would have brought it to the nurse. 12. Interview on 2/12/26 at 11:58 a.m. with RN N revealed:	F0761		

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F0761 SS = E	Continued from page 32 *The nurse who worked the during the night shift was supposed to check the medication room and the medication carts for expired medications monthly. *An inhaler was not to be left in a resident's room unless there was a physician's order and an assessment was completed to determine if a resident was able to safely self-administer their own medications. *She expected the staff to bring any medications found in a resident's room to the nurse. *She stated resident 15 would not be able to safely self-administer her medications. 13. Interview on 2/12/26 at 12:11 p.m. with ADON C revealed: *Medications were not to be stored in a resident's room without a physician's order and an assessment completed for the self-administration of medications. *She expected the staff to bring any medications found in a resident's room to the nurse. *Resident 15 would not be able to safely self-administer her medications. *Expired medications were not to be administered to the residents. *The medication room and medication carts were to be checked monthly for outdated medications by the director of nursing (DON), ADON, and the CMAs and then destroyed. *The provider's consultant pharmacist checked the medication room and medications carts for expired medications and to be sure items were stored according to the manufacturer's instructions and compliant with the state and federal regulations.	F0761		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880	Corrective Action Resident # 55 has been discharged from the facility. CMAs K and L have been educated on proper hand hygiene practices when passing medications which can affect residents #46 and #65 (3/11/26).	3/17/2026

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F0880 SS = E	Continued from page 33 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	Resident # 49 will have his drainage bag in a cover and not placed on the floor while to help prevent infections (2/12/26). All Staff members have been educated by the ADON on EBP policies and procedures related to infection control which could affect residents #3, #7, and #9 (3/12/26). Identification of Others All residents at Roling Hills can be affected by improper infection control. All staff have been Educated on hand hygiene, indwelling catheter care, and EBP infection control practices (3/12/26). Each Staff member was educated about their specific roles and responsibilities when it comes to infection control. Systematic Changes The ADON (Infection Preventionist) educated all staff related to Hand Hygiene, Indwelling Catheter Care, and EBP (3/12/26). She educated each staff member to their own roles and responsibilities according to their own job role. She will continue to do ongoing in-service training on infection control standards as needed. Monitoring The ADON/designee will conduct an audit to validate proper infection control practices that are being used by all staff related to hand hygiene, indwelling catheters, and/or the use of EBP. This will be included in the ongoing Infection control program that includes the IP tracking and trending and sharing this data monthly with the QAPI committee. Audits will be done on 10 – 12 staff members weekly for 4 weeks, then monthly for 3 months.	

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F0880 SS = E	Continued from page 34 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed infection prevention and control practices regarding: *Hand hygiene (handwashing) by two of two certified medication aides (CMA) (K and L) during medication administration for three of three sampled residents (46, 55 and 65). *An indwelling urinary catheter (flexible tubing inserted into the bladder to drain urine) being kept off the floor for one of one sampled residents (49). *The use of enhanced barrier precautions (EBP), glove and gown use when providing contact care, by the staff for three of three residents (3, 7, and 9) who were on enhanced barrier precautions (EBP), and one of one sampled resident (3) who was transferred by two of two staff members (certified nursing assistant (CNA) O and care assistant W) without using EBP. Findings include: 1. Observation and interview on 2/10/26 at 1:45 p.m. with CMA K revealed: *She had prepared resident 55's nebulizer (a device that converts liquid medications into inhalable mist) treatment after using her laptop computer to check the nebulizer order, she retrieved the nebulizer medication from inside the medication cart. *She entered resident 55's's room, and without first performing hand hygiene, she assembled the nebulizer tubing, nebulizer medication cup, and mask.	F0880	The ADON/designee will report and discuss the audits including any identified concerns, or non-compliance trends to the Quality Assurance Committee monthly. As long as the audits are showing a 90% or higher compliance rate, we will continue these audits as planned.	

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F0880 SS = E	Continued from page 35 *She placed the medication into the nebulizer cup and turned on the nebulizer machine. CMA K then put the nebulizer mask over the resident's nose and mouth and ensured the elastic band attached to the mask was placed behind the back of the resident's head to keep the mask in place. *CMA K stated she would return to the resident's room in 10 minutes to remove the mask from the resident's face, turn off the machine, and clean the nebulizer equipment. *After she exited resident 55's room, CMA K returned to the medication cart, and without performing hand hygiene, she prepared resident 46's medications for administration. *Following the above observation, CMA K acknowledged she should have performed hand hygiene upon entering resident 55's room before she handled the resident's nebulizer equipment and medication. *She agreed that after exiting resident 55's room, she should have but did not perform hand hygiene before she prepared resident 46's medications for administration. 2. Observation and interview on 2/11/26 at 8:00 a.m. with CMA L revealed: *That without first performing hand hygiene, she prepared resident 65's medications for administration to the resident. *After those medications were administered, CMA L performed hand hygiene. *CMA L stated it was expected that hand hygiene was performed both before and after medication administration for each resident. 3. Interview on 2/11/26 at 5:00 p.m. with assistant director of nursing (ADON) C regarding infection prevention and control practices revealed: *That hand hygiene was expected to be performed by all caregivers before and after all transitions in residents' care performed. *She confirmed that was not demonstrated by CMAs K and L in the above observation but it should have been.	F0880		

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F0880 SS = E	Continued from page 36 4. Review of the provider's revised 5/15/25 Nebulizer Therapy policy revealed: "2. Gather appropriate equipment and ordered medication." "4. Perform hand hygiene." 5. Review of the provider's revised 5/7/25 Medication Administration policy revealed: "4. Perform hand hygiene prior to administering medication per facility protocol and product." "18. Observe resident consumption of medication. 19. Wash hands using facility protocol and product." 6. Observation and interview on 2/10/26 at 2:50 p.m. with resident 49 in his room revealed: *He was sitting in his recliner with his feet elevated. *He stated that he was unable to transfer from his wheelchair to his recliner without the staff's assistance. *He had a urinary catheter, and the drainage bag was lying directly on the floor. *There was no dignity bag (a specialized cover to conceal urinary drainage bags from the public view) or other cover around the drainage bag. There was no barrier between the drainage bag and the floor to protect it from potential contamination. *He said he did not put the drainage bag on the floor, and then said, "I guess they [staff] put it on the floor when they got me in my chair." 7. Observation and interview on 2/11/26 at 10:30 a.m. with resident 49 in his room revealed: *He was sitting in his recliner with his feet elevated. *His catheter drainage bag was lying directly on the floor without a cover or a protective barrier. *He did not remember which staff member helped him get	F0880		

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F0880 SS = E	Continued from page 37 into his recliner that morning. 8. Observation and interview on 2/11/26 at 4:16 p.m. with CNAs P and Q in resident 49's room revealed: *Resident 49 was in his recliner with his feet elevated. *The catheter drainage bag was hanging on the elevated footrest of the recliner. *Neither CNA P or Q had hung the drainage bag on the recliner's footrest. *When asked about the previous observation of the drainage bag lying on the floor, both CNAs P and Q said that the drainage bag should not be lying directly on the floor. CNA Q stated, "That is unacceptable," and indicated there should be a barrier between the drainage bag and the floor to prevent potential contamination. 9. Interview on 2/12/26 at 10:09 a.m. with assistant director of nursing (ADON) C revealed: *Their policy was to place a resident's catheter drainage bag into a dignity bag. *She expected the staff to secure the dignity bag to the resident's bed when a resident was resting in a recliner or bed. *The catheter drainage bags were not be directly on the floor due to infection control concerns. 10. Review of the provider's 6/6/25 Indwelling Catheter Use and Removal policy revealed: *"Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures." *"Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodgement of the catheter;" *"Securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioning below the level of the bladder."	F0880		

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F0880 SS = E	Continued from page 38 11. Review of the provider's 5/2/25 Catheter Care policy revealed: *"Privacy bags will be available and catheter drainage bags will be covered at all times while in use." 12. Review of the provider's undated Catheter Care Competency Assessment revealed: *"The purpose of this procedure is to prevent catheter-associated urinary tract infections." *"Infection Control" -"Be sure the catheter tubing and drainage bag are kept off the floor. 13. Observation and interview on 2/10/26 at 2:44 p.m. with resident 9 in her room revealed: *There was no personal protective equipment (PPE), which would include a gown or gloves, or sign on resident 9's door indicating she was on EBPs. *Resident 9 stated the staff did not wear a gown or gloves when they assisted her with toileting, getting dressed or transferring her. 14. Review of resident 9's electronic medical record (EMR) revealed: *She was admitted to the facility on 12/6/24. *Her 12/17/25 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. *She had a 12/19/25 physician's order for "Enhanced Barrier Precautions r/t [related to] MDRO [multi drug resistant organism (an organism that is resistant to most antibiotics)]: Hx [history] of E. coli [Escherichia coli (a bacteria that lives in the intestine, with some strains of these bacteria causing diarrhea, urinary tract infections, and pneumonia)] per standing orders." *Her 2/10/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated "Enhanced barrier precautions r/t infection or colonization with CDC [Center for Disease Control] -targeted MDRO" initiated on 12/19/25.	F0880		

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F0880 SS = E	Continued from page 39 -"Gown and gloves [were to be worn by staff] during high-contact personal care activities". 15. Observation on 2/10/26 at 4:39 p.m. revealed there was no PPE or an EBP sign on resident 3's door to indicate he was on EBP. 16. Observation on 2/11/26 at 8:24 a.m. of resident 3 in his room revealed: *CNA O and care assistant W transferred resident 3, using a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) from his wheelchair to the toilet. *CNA O and care assistant W were not wearing PPE. 17. Observation and interview on 2/11/26 at 3:24 p.m. with resident 3 in his room revealed: *He had a dialysis port in his right upper chest. *Resident 3 stated the staff did not wear a gown or gloves when they assisted him to the toilet, getting dressed, or transferred him. 18. Review of resident 3's EMR revealed: *He was admitted to the facility on 8/14/25. *His 11/21/25 BIMS assessment score was 10, which indicated his cognition was moderately impaired. *He had a 11/19/25 physician's order for "Enhanced Barrier Precautions d/t [due to] dialysis port [a surgically implanted catheter that allows blood to be removed, cleaned by a machine, and returned to the body for people with kidney failure]." *His 2/10/26 care plan stated, "Enhanced barrier precautions d/t dialysis port" initiated on 11/19/25. 19. Observation and interview on 2/11/26 at 10:04 a.m. with resident 7 in her room revealed: *There was no PPE or EBP sign on resident 7's door that indicated she was on EBP. *Resident 7 stated the staff did not wear a gown or gloves when they assisted her with toileting, bathing, or getting dressed. 20. Review of resident 7's EMR revealed:	F0880		

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F0880 SS = E	Continued from page 40 *She was admitted to the facility on 2/9/24. *Her 12/22/25 BIMS assessment score was 10, which indicated her cognition was moderately impaired. *She had a 2/27/25 physician's order for "Enhanced Barrier Precautions r/t MDRO". *Her 2/10/26 care plan stated, "Enhanced barrier precautions r/t infection or colonization with CDC-targeted MDRO SPECIFY: hx of ESBL [Extended-spectrum beta-lactamase (an enzyme produced by bacteria that makes the resistant to many antibiotics)] (1/2/2020)" initiated on 11/18/24. -"Don [put on] gown and gloves during high-contact personal care activities." 21. Review of the provider's undated resident care sheet (an abbreviated resource for staff members to refer to when providing resident care) revealed: *Resident 3 was not indicated as being on EBP. *Resident 7 was indicated to require EBP due to a wound and a line (an intravenous line, a feeding tube, or a dialysis port). *Resident 9 was indicated to require EBP due to an MDRO. 22. Interview on 12/11/26 at 2:01 p.m. with CNA O revealed: *She would know if a resident was on EBP if there was PPE and an EBP sign hanging on the outside of the door. *Residents 3 and 7 were not on EBP because there was no PPE or an EBP sign hanging on the outside of their rooms that indicated they were on EBP. *Resident 3 was admitted to the facility with a dialysis access port. *CNA O stated resident 3 "probably" should have been on EBP, since his admission, due to his dialysis access port. 23. Interview on 2/12/26 at 12:11 p.m. with ADON C revealed: *The staff knew a resident was on EBP when there was PPE and an EBP sign hanging on the outside of the	F0880		

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F0880 SS = E	Continued from page 41 resident's door. *The residents were to be on EBP if they had a urinary catheter, a feeding tube, a wound, a history of or a current MDRO, or a dialysis access port. *A gown and a pair of gloves were to be worn anytime the staff provided direct care for residents on EBP. *Resident 3 had a dialysis access port when he was admitted to the facility. *Resident 3 was supposed to be on EBP, but when he moved rooms, his EBP sign and PPE must not have moved with him. *Resident 7 was to be on EBP for her history of ESBL in her urine. *She was not aware that resident 7 did not have PPE or an EBP sign on her door to indicate to the staff that she was on EBP. *On 12/19/25 medical director V ordered resident 9 to be on EBP, ADON C stated she did not know why he had written that order. *She was not aware resident 9 did not have PPE or an EBP sign on her door. 24. The director of nursing (DON) was not in the facility or available for an interview during the survey. 25. Review of the provider's 4/11/25 Enhanced Barrier Precautions (EBP) policy revealed: *"'Enhanced barrier precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employes targeted gown and gloves during high contact resident care activities." *"The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-[contact resident care activities.]" *"The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC but may be considered epidemiologically important."	F0880		

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 02/12/2026

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
F0880 SS = E	Continued from page 42 *"Implementation of Enhanced Barrier Precautions: -Make gown and gloves available immediately near or outside of the resident's room." -"Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room)." -"The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education." *"High -contact resident care activities include:" -"Dressing[.]" -"Bathing[.]" -"Transferring[.]" -"Providing hygiene[.] -"Changing linens[.]" -"Changing briefs or assisting with toileting[.]" -"Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC [peripherally inserted central catheter] lines, midline catheters[.]" -"Wound care: any skin opening requiring a dressing[.]"	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435035	A. BUILDING B. WING	02/10/2026

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
E0000	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 2/10/2026. Rolling Hills Healthcare was found in compliance.	E0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435035	A. BUILDING 01 - MAIN BUILDING 0... B. WING	02/10/2026

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
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 2/10/2026 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Rolling Hills Healthcare was found in compliance.	K0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3/13/2026

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 _____	02/12/2026

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 2/10/26 through 2/12/26. Rolling Hills Healthcare was found not in compliance with the following requirements: S290 and S301.	S 000		
S 290	44:73:07:05 Food Supply The facility shall maintain an on-site supply of perishable and nonperishable foods to meet planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of the facility's emergency preparedness plan. A facility may use military meals ready to eat and dried milk in an emergency event according to the facility's emergency response plan. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure an emergency supply of non-perishable food and beverages were available to implement their designated disaster menu that was a part of their emergency preparedness plan. Findings include: 1. Observation and interview on 2/10/26 at 9:15 a.m. with dietary supervisor E in the kitchen revealed there was a storage rack with six one-pound cans of various fruits, vegetables, gravy, cream soups, and beans. There were bags of powdered milk, juices, powdered beverage mixes, and snacks in a separate dry food storage area. Inventory from both food storage areas would be used to implement the provider's	S 290	Corrective Action: The emergency food supply has been ordered and is stocked in the kitchen storage. The emergency food is adequate and based on our emergency food menu. Identifications of Others: All residents are at risk of not having adequate food during an emergency. The facility does have the emergency food supply ready to go in case of an emergency. Systemic Changes: The Administrator and the Dietary Manager met and approved the emergency food supply menu. Food to match this menu was ordered and is now available in case of an emergency (3/12/26). The Dietary manger will be responsible for inventory, rotating, and replacing this emergency food monthly.	3/13/2026

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

TITLE: Administrator

(X6) DATE: 3/13/2026

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 _____	02/12/2026

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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S 290	Continued From page 1 designated disaster menu. 2. Interview and review of the provider's 7 Day Disaster Menu on 2/10/26 at 1:00 p.m. with dietary supervisor E revealed the protein bars listed on that menu that were to be provided every other day at breakfast were not available. Canned tuna , ham, or chicken were listed on that menu to be provided daily for lunch, but they were not available either. Dietary supervisor E acknowledged that the facility was not maintaining an emergency food supply that enabled them to implement their disaster menu. It was not clear what amount of non-perishable food and beverages were needed for the residents in the event of an emergency. Dietary supervsor stated it was "a work in progress." 3. Interview on 2/11/26 at 3:15 p.m. with administrator A revealed the provider's emergency food supply was last inventoried in June 2025. He did not known if a sufficient quantity of non-perishable food and beverages to implement their disaster menu in the event of an emergency was available for use. Dietary supervisor E was responsible for ensuring that occurred. 4. Review of the provider's revised June 2025 Emergency Food Supply policy revealed: -"1. The Dietary Manager maintained a three day supply of nonperishable foods and supplies of disposable dishes/utensils. "The emergency food is rotated/replenished every six months." -"3. The amount of food needed is estimated based on the facility assessment, and considers census, total staff, and average number of volunteers/visitors."	S 290	Monitoring/QAPI: The DM/designee will monitor and document the inventory of the emergency food supply monthly. The DM/designee will report to the QAPI committee monthly that the emergency supply is up to date and available. Any concerns that come up will also be reported to the QAPI committee.	

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 _____	02/12/2026

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 290	Continued From page 2 5. Review of page 2 of the provider's 2009 Emergency Preparedness Planning and Resource Manual, Section IV: Emergency Preparedness and Planning an Emergency Food Supply form revealed there was a space on that form beside each individually listed food and beverage item to record dates when those items were inventoried and the amount of each item that was available at the time of the inventory to use in the event of an emergency. The last inventory was documented as having occurred on 6/19/25. The area on that form that indicated the amount of each food and beverage item that was needed for the residents during an emergency was not completed. Without that information, it was not known if the provider's current emergency food supply would have met the nutritional needs of the residents.	S 290		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service;	S 301	Corrective Action: The Dietary Manager completed the required training for all the current dietary staff members. All new hires in the dietary department will receive the required training within the first 30 days of employment. Identifications of Others: Not having staff complete the required training may put residents at risk. Human Resources will work with the Dietary manager to ensure required training is completed in a timely manner.	3/13/2026

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 _____	02/12/2026

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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S 301	Continued From page 3 (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and personnel file review, the provider failed to ensure three of three dietary staff reviewed completed the required dietary training annually (dietary aide J) or within 30 days of their hire date (dietary aide S and cook I). Findings include: 1. Review of dietary aide (DA) J's personnel file revealed his hire date was 10/8/24. There was no documentation that he had completed the required annual dietary training. 2. Review of DA S's personnel files revealed her hire date was 1/9/26. DA S completed three of the nine required orientation trainings (handwashing, serving/distribution, and nutrition/hydration) within 30 days of hire. There was no documentation that DA S completed the required dietary trainings for food safety, foodborne illnesses, food safety, leftovers, time/temperature control, and sanitation. 3. Review of Cook I's personnel file revealed hire date was 11/6/25. Cook I completed three of the nine required orientation trainings (handwashing, serving/distribution, and nutrition/hydration) within 30 days of hire. There was no documentation that cook I completed the required dietary trainings for food safety, foodborne illnesses, food safety, leftovers, time/temperature control, and sanitation. 4. Interview and review of the provider's General	S 301	Systemic Changes: The Human Resources Director and the Dietary Manager met to review and approved the required training for the dietary department. They then gave this training to all members of the dietary staff. They also put together a plan to complete ongoing training as required. New staff in the dietary department will receive this required training as part of their orientation and onboarding. Monitoring/QAPI: The HR/designee will monitor and document the training for the dietary department and work with the DM for ongoing required training. The HR/designee will report to the QAPI committee monthly on all required training including that of the dietary department. Any concerns that come up will also be reported to the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 301	Continued From page 4 Orientation Agenda and sign-off form on 2/11/26 at 2:00 p.m. with human resources coordinator F revealed dietary supervisor E was responsible for providing training regarding nutrition/hydration and serving/distribution for newly hired staff. Assistant director of nursing (ADON) C was responsible for providing training regarding infection control that included handwashing for newly hired staff. The provider also used an on-line education program (Healthcare Academy) for employee training, but that program dif not address any of the required dietary trainings for the topics of food safety, foodborne illnesses, food safety, leftovers, time/temperature control, and sanitation. 5. Interview on 2/11/26 at 5:45 p.m. with dietary supervisor E revealed he provided ongoing training for his food service staff that included all nine required dietary training topics, but he did not have a process for tracking when he provided those trainings or which dietary staff had attented those trainings. He acknowledged that the orientation and ongoing required dietary service training requirement was met for dietary employees I, J, and S. 6. On 2/11/26 at 4:45 p.m., a policy regarding initial and ongoing dietary staff training was requested from regional nurse consultant D. On 2/11/26 at 5:00 p.m., she confirmed the provider did not have a policy that addressed that.	S 301		