**Multiple Construction**

**Building**

- **Bbling**

**Wing**

- **Winging**

---

**Name of Provider or Supplier:** Rolling Hills Healthcare

**Street Address, City, State, Zip Code:** 2200 13th Ave, Belle Fourche, SD 57717

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**Summary Statement of Deficiencies**

- **ID Prefix Tag:** F 000

  **Initial Comments**

  Surveyor: 29162
  An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/20/19 through 5/23/19. Rolling Hills Healthcare was found not in compliance with the following requirements: F550, F656, F684, F686, F689, F897, F745, F888, and F880.

  A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/20/19 through 5/23/19. Areas surveyed included quality of resident care and treatment. Rolling Hills Healthcare was found not in compliance with the following requirements: F684 and F889.

- **ID Prefix Tag:** F 550

  **Resident Rights/Exercise of Rights**

  CFR(a): 483.10(a)(1)(2)(b)(1)(2)

  §483.10(a) Resident Rights.
  The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident’s individuality. The facility must protect and promote the rights of the resident.

  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis.

**Corrective Actions:**

6/20/2019

- The DON/designee reviewed and evaluated Resident S2 on 06/10/2019 for proper toileting with full body sling with lift (Hoyer Lift) to include use of a bedside commode. Resident, representative, and physician were notified. Any new orders were noted and care plan updated as applicable.

- The DON/designee reviewed and evaluated Resident 73 on 6/10/2019 for proper toileting with a (Hoyer Lift) to include use of a bedside commode.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREVIOUS EVENT</th>
<th>CURRENT EVENT</th>
<th>COMPLIANCE HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>F550</td>
<td>Continued From page 1</td>
<td>Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.</td>
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<tr>
<td></td>
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<td>The DON/designee reviewed Resident 125’s evaluation by therapy completed on 5/22/2019 and validated that resident is able to use commode. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.</td>
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<td>Identification of Others:</td>
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<tr>
<td></td>
<td></td>
<td>DON, therapy or Designee will review and evaluate residents who use a Hoyer lift for proper toileting to include use of a bedside commode or toilet. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.</td>
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<td>Systemic Changes:</td>
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<td></td>
<td>Administrator, DON, interdisciplinary team (IDT) and medical director reviewed and approved the Quality of Life-Dignity Policy about ensuring individual right and choice about toileting.</td>
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</tbody>
</table>
Continued from page 2

- She was an extensive assist with a two plus person physical assist for:
  -- Bed mobility.
  -- Transfers.
  -- Dressing.
  -- Toilet use.
  -- Personal hygiene.
  -- Bathing.

Interview on 5/21/19 at 8:06 a.m. after resident 52's brief change with certified nurse aides (CNAs) O and P revealed:
* She was a Hoyer lift resident.
* Residents that are a Hoyer lift and wear a brief are not brought into the bathroom.
  - It is hard to get the Hoyer sling off of the resident so they could use the toilet or commode.
* They stated residents urinate and have bowel movements (BM) in their brief.
* Residents are then changed.
* Residents can have a bedpan if they choose.
* They are not given the choice to use the toilet.

Interview on 5/22/19 at 1:18 p.m. with CNA M concerning resident 52 revealed:
* If a resident is a Hoyer lift, their choice is to use a bedpan or urinate or have a BM in their brief.
  - We check her brief when we lay her down.
  - She won't use a bedpan.
  - She uses a hoyer lift.
  - We do not toilet her.
  - "I don't know what else we're suppose to do if she will not use a bedpan. She is a Hoyer lift."

Interview on 5/22/19 at 1:34 p.m. during resident 52's brief change with CNAs H and N revealed:
* They both state they check on her every two hours.
* She urinates and has BM's in her brief.

Administrator/DON or designee will educate licensed nurses, nurse aides and therapy staff on the Quality of Life-Dignity Policy and include:
- ensuring each resident is cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.
- all residents are treated with dignity and assisted in maintaining and enhancing self-esteem and self-worth;
- demeaning practices and standards of care that compromise dignity are prohibited
- ensuring staff promote dignity by promptly responding to a resident's request for toileting.

Education will include their roles and responsibilities for resident's choice with toileting to include staff roles and responsibilities of assessing a resident using a Hoyer Lift and using proper equipment for toileting and using a bedside commode as well as knowing where to find equipment.

This education will be provided no later than 6/20/2019. Those who have not received education prior to 6/20/2019 will be educated prior to their next shift worked.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 550</td>
<td>Continued From page 3</td>
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<td>F 550</td>
<td>Monitoring/QAPI:</td>
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<td>Administrator/DON or designee will conduct monitoring 3 times a week through chart review, observation and interview to validate that residents who require use of a Hoyer Lift are being offered proper toileting based on assessment to include resident choice to use a bedside commode or toilet. Monitoring will randomly include residents 5, 73, 125 and staff O, P, M, H, N, Q, A, B, C, D, E, U.</td>
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<td>Administrator/DON or designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.</td>
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<tr>
<td>*She is a Hoyer lift.</td>
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<td>*There is no way to toilet her or put her on the commode.</td>
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<tr>
<td>-They do not have the correct Hoyer sling to do that.</td>
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<td>Surveyor: 40772</td>
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<td>2. Review of resident 73's 3/29/19 MDS assessment revealed:</td>
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<td>*She had been admitted on 12/12/18.</td>
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<td>*Her BIMS score had been thirteen indicating her cognition was intact.</td>
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<td>*She required the extensive assistance of one staff member for personal hygiene.</td>
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<td>*She was totally dependent on two or more staff members for:</td>
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<td>-Dressing.</td>
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<td>-Transfers.</td>
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<td>-Toilet use.</td>
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<td>-Bed mobility.</td>
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<td>*She had an indwelling catheter and had been frequently incontinent of bowel.</td>
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<tr>
<td>Interview on 5/21/19 at 7:40 a.m. with resident 73 revealed:</td>
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<td>*She could not walk or stand and required a total lift for transfer.</td>
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<td>*She could not use the toilet for bowel elimination due to needing the total body lift.</td>
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<td>*She stated it would be too hard for the staff to get her into the bathroom and onto a toilet.</td>
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<tr>
<td>*She did not know what a commode was and had never been offered one for bowel elimination.</td>
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<tr>
<td>Interview on 5/21/19 at 8:00 a.m. with CNA Q revealed, residents who use a total body lift must use the bed pan.</td>
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<td>Interview on 5/21/19 at 9:23 a.m. with CNA A revealed, residents using a total lift had to use the</td>
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F 550 Continued From page 4

bed pan due to not being able to access the toilet with the lifts.

Interview on 5/21/19 at 9:26 a.m. with physical therapy assistant (PTA) B revealed:
*He did the nursing assistant training for lift use.
*Residents cannot be toileted with a total lift due the full body slings.

Interview on 5/22/19 at 11:01 a.m. with unlicensed assisitive personnel (UAP) C revealed, residents who required a total lift had to use the bed pan.

Interview on 5/22/19 at 11:02 a.m. with UAP D revealed:
*The provider did have mesh slings that would allow for toileting with a total lift.
*She was not aware of this until a few days prior.
-She was informed of these slings due to another resident who currently used the toilet being evaluated for a total lift.
*There were no bathrooms big enough to get into with a resident in a total lift.

Interview on 5/22/19 at 11:04 a.m. with CNA E revealed, she did not believe residents who required a total lift could use a toilet or commode.

Interview of 5/22/19 at 2:10 p.m. with resident 73 revealed:
*She was unable to get onto a bed pan and had to eliminate her bowels in her incontinent products.
*When asked if she felt embarrassed about having to use her incontinent product for bowel elimination she stated, "I have to go in my diaper and that is it".
*She then changed the topic to her upcoming
F 550 Continued From page 5

birthday party and the weather.
Surveyor: 29162
3. Review of resident 125's medical record revealed:
*An admission date of 5/13/19.
*A BIMs of thirteen that indicated she had been cognitively intact.
*Her admission MDS assessment revealed:
-She required extensive assistance with two person physical assistance for:
--Bed mobility.
--Transfers.
--Dressing.
--Personal hygiene.
--Bathing.
-She had an indwelling urinary catheter.
-She had been frequently incontinent of bowel.

Interview on 5/22/19 at 11:02 a.m. with resident 125 revealed she:
*Had to use the bedpan for bowel elimination.
*Stated she:
-Did not like using the bedpan.
-It had been embarrassing for her to ask to use the bedpan.
-Had been told by staff she "had to use the bedpan for bowel elimination."

Interview on 5/22/19 at 8:30 a.m. with CNA U revealed she stated:
*Resident 125 used the bedpan for bowel movements.
*That was how she had been told to assist her by the nurses and therapy.
*She thought the resident could probably use a commode but could not do that unless therapy told them they could.

Observation on 5/22/19 at 2:00 p.m. of resident
Continued From page 6
125 while she had been in the therapy room revealed:
"She was sitting in a chair with her right leg extended and elevated on a therapy ball.
"The certified occupation therapy assistant W and CNA U were looking for a commode.
"It took fifteen minutes to find a commode."
"That commode was to have been used to do a "dry run" transfer for the resident to use a commode for bowel elimination.

Observation on 5/22/19 at 2:35 p.m. of resident 125 in her room revealed a stand aid transfer done by CNA U and PTA B. They assisted the resident onto the commode. The resident had a continent bowel movement.

Interview on 5/23/19 at 9:45 a.m. with resident 125 in the therapy room revealed she stated "It is a good thing I don't have to use that bedpan anymore. I could do it but really did not like it. It is much better now when I can use a commode. Easier too."

Interview 5/23/19 at 10:45 a.m. with the DON confirmed resident 125 should not have had to use the bedpan for bowel elimination. She stated "There are alternate ways."

Review of providers Qtr 3, 2018 Quality of Life-Dignity policy revealed:
"Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.
"Treated with dignity meant the residents will be assisted in maintaining and enhancing his or her self-esteem and and self-worth.
"Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
ROLLING HILLS HEALTHCARE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2200 13TH AVE
BELLE FOURCHE, SD 57717

**ID PREFIX TAG**
435935

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGBC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 550</td>
<td>Continued From page 7 promote dignity and assist residents as needed by: promptly responding to resident's request for toileting.</td>
<td>F 550</td>
<td>Corrective Actions:</td>
<td>6/20/2019</td>
</tr>
<tr>
<td>F 656 SS=E</td>
<td>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s) - (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document...</td>
<td>F 656</td>
<td>...</td>
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</table>
| F 656 | Continued From page 8 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, and policy review, the provider failed to develop and revise individual care plans to reflect the needs and desires for eight of nineteen sampled residents (9, 23, 45, 52, 53, 65, 62, and 73). Findings include:

1. Review of resident 56's care plan with a print date of 5/22/19 revealed:
   * A focus area for a pressure wound.
   * A new skin area concern on 5/21/19 had not been identified on the current care plan. Refer to F686 finding 4.

2. Review of resident 62's current care plan printed on 5/22/19 revealed:
   * A focus area for skin breakdown.
   * The interventions for the above areas had been "I am refusing foam boots, staff will continue to offer these. Offer pillows to offload heels when in bed." Refer to F686 finding 4.
   Surveyor: 40053 Resident #52

3. Review of resident 62's care plan revealed:
   **Focus:**
   - Need assistance in:
   - Dressing.

| F 656 | Social Services/Designee reviewed and updated resident 23's care plan interventions for physical, mental, psychosocial well-being, support for transition to Long Term Care, history of flat affect, and counseling per resident's choice. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

| F 656 | DON/Designee reviewed and updated resident 9's care plan with individual and non-pharmacological interventions to prevent facility acquired pressure ulcers including prevention with external medical devices, and an evaluation for air mattress. The Brace/splint to hand was not added to care plan due to being discontinued. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

<p>| F 656 | DON/Designee reviewed and updated resident 45's care plan with individual and non-pharmacological interventions to prevent facility acquired pressure ulcers and transfer status. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable. |</p>
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>F 656</td>
<td>Continued From page 9</td>
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<td>- Grooming.</td>
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<td>- Bathing.</td>
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<td>- Date Initiated: 10/11/18.“”</td>
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<td></td>
<td>&quot;&quot;Interventions:</td>
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<td>- I need extensive assist of one staff with my:</td>
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<td>- Dressing.</td>
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<td>- Grooming.</td>
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<td>- Bathing.</td>
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<td></td>
<td>- Date Initiated: 10/11/18.&quot;&quot;</td>
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<td>&quot;&quot;Her 4/16/19 quarterly minimum data set revealed:</td>
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<td>- She was an extensive assist with a two plus person physical assistant for:</td>
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<td>-- Dressing.</td>
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<td>-- Personal hygiene.</td>
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<td>-- Bathing.</td>
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<td>**Focus:</td>
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<tr>
<td></td>
<td>- Transfers/Bed Mobility/Ambulation.</td>
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<td>- Date Initiated: 10/11/18.&quot;&quot;</td>
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<td>&quot;&quot;Interventions:</td>
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<td>- Staff use a sit to stand lift to transfer me.</td>
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<td>- I need extensive assistance of one staff person with:</td>
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<td>-- Bed Mobility.</td>
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<td>-- Transfers.</td>
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<td>-- Ambulation.</td>
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<td>- Date Initiated: 10/11/18.&quot;&quot;</td>
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<td>**Focus:</td>
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<td>- I am at risk for falls.</td>
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<td>- Date Initiated: 10/11/18.</td>
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<td>- Revision on 11/8/18.</td>
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<td>**Interventions:</td>
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<td>- Do not leave me unattended in my wheel chair in my room, as I may fall out of it.</td>
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<td>- Date Initiated: 1/2/19.&quot;&quot;</td>
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</table>

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<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 656</td>
<td>DON/Designee reviewed and updated resident 73's care plan with repositioning interventions. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.</td>
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</tbody>
</table>

DON/Designee reviewed and updated resident 53's care plan with contact precautions regarding ESBL. Current pressure ulcer was added to care plan on 4/29/2019. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

Identification of Others:

DON/Designee reviewed residents with changes affecting care plans to validate that their care plans were updated and accurate. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

Administrator/DON will add discussion of changes affecting care plans to daily Quality Conference meetings. Care plans will be updated during meeting with indicated changes.
<table>
<thead>
<tr>
<th>ID</th>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCESSED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
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</table>
| F656 | Continued From page 10 | her room.  
*She was a Hoyer lift.  
*The careplan needed to be updated to match the Minimum Data Set and her needs.  
Refer to F550, finding 1 and F684, finding 1.  
Surveyor: 40772  
4. Resident 23 did not have a complete and comprehensive care plan.  
Refer to F745 finding 2.  
5. Resident 9 did not have a complete and comprehensive care plan.  
Refer to F868 finding 1.  
6. Resident 45 did not have a complete and comprehensive care plan. Please, refer to F666 finding 2.  
7. Resident 73 did not have a complete and comprehensive care plan. Please, refer to F666 finding 3.  
Surveyor: 41083  
8. Review of resident 53's medical record revealed he had:  
*A diagnosis of: Type 2 diabetes mellitus with foot ulcer, paroxysmal atrial fibrillation, end stage renal disease, and non-pressure chronic ulcer of right heel and left foot with unspecified severity.  
*Admitted on 1/22/18.  
*A history of extended spectrum beta lactamase (ESBL).  
*A new pressure ulcer on his left calf which had been discovered on 3/11/19.  
Review of resident 53's 3/15/19 revised care plan revealed:  
*No documentation found on his care plan |

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| F656 | Systemic Changes:  
Administrator, DON, IDT and medical director reviewed and accepted Care Plans Comprehensive Person-Centered Policy and procedure about ensuring a complete and accurate care plan is available for residents and staff use.  
Administrator will educate DON, IDT and pertinent staff responsible for care plan accuracy on the Care plans Comprehensive Person-Centered Policy and procedures. Education will include ensuring care plans are complete and accurate, individualized, includes measurable objectives and timetables to meet the resident's physical, mental, psychosocial and functional needs and desires, ensuring care plans are developed and implemented for each resident and are revised and updated with information and changes regarding the resident's condition and cares.  
This education will be provided no later than 6/20/2019. Those who have not received education prior to 6/20/2019 will be educated prior to their next shift worked. |

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**Form Approved: 03/07/2019**  
**OMB No: 0938-0391**  
**Printed: 05/23/2019**
**NAME OF PROVIDER OR SUPPLIER**
ROLLING HILLS HEALTHCARE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2296 13TH AVE
BELLE FOURCHE, SD 57717

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<tr>
<td>F 656</td>
<td>Continued From page 11 regarding the 3/11/19 pressure ulcer on his left calf until 4/29/19. *On 3/15/19 his contact precautions for ESBL had been discontinued. *Staff had continued to follow contact precaution practices after 3/15/19. *There was no physician order for contact precautions. Interview on 5/23/19 at 11:53 a.m. with the administrator and DON regarding resident 53's care plan: **Confirmed the care plan should have been revised. **Acknowledged the care plan had not been updated to reflect his current status. Review of the provider's dated Quarter 3, 2018 Care Plans, Comprehensive Person-Centered policy and procedure revealed: **&quot;A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.&quot; **&quot;Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.&quot;</td>
<td>F 656</td>
<td>Monitoring/QAPI: The Administrator/DON or designee will conduct monitoring 3 times a week through chart review, observation and interview to validate that resident care plans are accurate, individualized, includes measurable objectives and timetables to meet the resident's physical, mental, psychosocial and functional needs and desires with timely updates regarding changes in the residents condition and cares. Monitoring will randomly include residents 9, 23, 45, 52, 53, 566, 62, and 73. Administrator/DON or designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.</td>
<td>6/20/2019</td>
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<tr>
<td>F 684</td>
<td>Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of</td>
<td>F 684</td>
<td>Corrective Action: DON/designee has reviewed and validated a repositioning and toileting schedule for Resident 52. No immediate correction action could be taken for cares or documentation provided to resident 52 on 5/22/2019.</td>
<td>6/20/2019</td>
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Continued From page 12
practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:
Surveyor: 40063
Based on observation, interview, record review, and policy review, the provider failed to ensure necessary care and services was provided for two of twelve sampled residents (52 and 56) as evidenced by:
*Not giving a timely opportunity to use a toilet or commode and not having a repositioning schedule in place to prevent decline for resident 52.
*Not investigating a skin tear of unknown origin and not providing an ordered needed treatment to a swollen surgical site for resident 56.
Findings include:

1. Observation on 5/22/19 at 1:14 p.m. of resident 52 in her room revealed:
*She was alone in her room sitting in her wheelchair (w/c) with her back to the door.
*There was an overbed table in front of her with her lunch on it.
*There was a large wet area on the floor behind her w/c that was yellow colored.
*There was a bubble cup on the floor.
*She had gray sweat pants on.
*Those sweat pants were wet between her legs where she was sitting.
*The left front hip crease area of her sweat pants were also wet.

Observation and interview on 5/22/19 at 1:18 p.m. of resident 52 in her room revealed:
*Certified nurse aide (CNA) M walked into the room.

Additional documentation requirements have been added to chart for turning and repositioning and toileting resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

DON/designee reviewed and documented cause of Resident 56's skin tear 5/28/2019. No immediate correction action could be taken for absent documentation upon recognition. No immediate corrective action could be taken to provide ice to swollen area on 5/22/2019. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

DON/Designee reviewed and verified residents documentation records and will ensure accurate documentation requirements are added as indicated into residents medical record to ensure accurate and complete documentation for toileting, turning and repositioning. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.
Continued From page 13

*She noticed the wet area on the floor and to the resident's sweat pants.
*She stated she had offered to lay her down at approximately 10:00 a.m. so she could change her brief.
- The resident had refused.
*She used her Walkie Talkie to ask for assistance to the room.
*She left and returned with a mop and bucket.
*She mopped up the wet area on the floor behind her w/c.
*She picked the bubble cup up from the floor and put it on her overbed table.
*She went into the bathroom and without washing her hands she put on gloves.

Observation and Interview on 5/22/19 at 1:34 p.m. of resident 52 in her room revealed:
*CNA's H and I entered the room.
*CNA I stated that he and another CNA had changed the resident's brief at 11:50 a.m.
- She had had a bowel movement (BM).
- When asked, CNA I stated that he had documented that brief change.
*CNA H states:
- They check on her every two hours.
- They do not have the correct Hoyer sling to take her to the toilet or put her on a commode.
- She is a Hoyer lift so there is no way to toilet her.
*Both CNAs I and M agree with CNA H's above statements.
*At 1:38 p.m. CNA M removes her gloves.
- Did not perform hand hygiene.
- Left the room.

Observation on 5/22/19 at 1:38 p.m. of resident 52 reveals:
*CNA's H and I have used the Hoyer lift to lay her on her bed.

DON/Designee reviewed and verified residents with current injuries to ensure recognition, assessment and documentation of investigation was appropriately completed. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

Systemic Changes:
Administrator/DON or designee will provide education to licensed nurses and nurse aides on Resident Quality of Care to ensure comprehension of roles and responsibilities to assure necessary cares and services are provided to residents by giving them a timely opportunity to use a toilet or commode and ensuring repositioning schedules are in place. Education provided will include staff M, H, I, J.

Administrator/DON or designee will educate nursing staff on facility's Abuse and Neglect Clinical Protocol to ensure appropriate injury assessment and recognition and investigation of a skin tear of unknown origin, and ensuring ordered services are provided as ordered or needed for treatment. Education provided will include staff M, H, I, J.
Administrator will educate DON to ensure Resident Quality of Care care and services are supervised as provided to the resident to include immediate investigation of skin tears as identified in an Injury Assessment and documentation, and ensure supervision of services are provided as ordered.

This education will be provided no later than 6/20/2019. Those who have not received education prior to 6/20/2019 will be educated prior to their next shift worked.

Monitoring/QAPI:
DON/Designee will conduct monitoring 3 times a week to validate that necessary care and services are provided to residents by allowing a timely opportunity to use a toilet or commode, and a repositioning schedule is in place. Monitoring will randomly include resident 52.

DON/Designee will conduct monitoring 3 times a week through chart review, observation and interviews to validate ordered and as needed services are provided to residents as applicable. Monitoring will randomly include resident 56.
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<td>F 684</td>
<td>Continued From page 15</td>
<td>*Entering or leaving her room. *Changing her brief. *Repositioning her.</td>
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<td>F 684</td>
<td>Administrator/DON or designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.</td>
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*They should not be told or allowed to:
- Urinate in their brief.
- Have a BM in their brief.
- And then be changed in piece of toileting, unless they have refused toilettng or a bedpan.

*There is no specific toileting schedule for a resident that wears briefs and is a Hoyer lift.

Record review of the CNAs 5/22/19 continence and BM task documentation revealed:
*At 3:40 a.m. she was incontinent and had no BM.
*At 1:49 p.m. and 1:50 p.m. she was incontinent and had a medium BM.
*There was no documentation that at 10:00 a.m. the resident refused a brief change as CNA M stated at 1:18 p.m. above.
*There was no documentation that at 11:50 a.m. a brief change had been done as CNA I had stated at 1:34 p.m. above.

Surveyor: 29162
2. Observation and interview on 5/21/19 at 1:40 p.m. of LPN J while she completed wound care for the resident revealed:
*LPN J stated:
- Resident 66's [surgical area] looks "quite swollen today."
- She did not provide ice for the surgical site even though there had been an order dated 5/2/19 that stated "May ice swollen area on [surgical site] for no more that 20 minutes per hour as needed for wound care."
- She had been unsure of what happened to the resident's left forearm where there had been a two inch optifoam gentle dressing in place.
--The first treatment for that skin tear had been on 5/6/19.
--A skilled progress note on 5/7/19 stated "Resident has a skin tear to right forearm,
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<td>dressing CDI, [clean, dry, intact] to be changed every 3 days or PRN.&quot;</td>
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<td>--She could not identify any additional nursing progress notes or reports related to the skin tear on the resident's left arm.</td>
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<td>Interview on 5/23/19 at 10:45 a.m. with the DON regarding resident 56's swollen surgical site and</td>
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<td>skin tear on her right forearm confirmed:</td>
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<td>*The ordered treatment of ice should have been completed for the resident.</td>
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<td>*The skin tear on her right forearm should have been documented in the progress notes and</td>
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<td>investigated on 5/6/19 by the identifying nurse.</td>
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<td>Review of the provider's Qtr 3, 2018 Abuse and Neglect Clinical Protocol revealed:</td>
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<td>&quot;Assessment and Recognition; The nurse will assess the individual and document related findings.</td>
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<td>Assessment data will include: a. Injury assessment.&quot;</td>
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<td>Review of the providers Director of Nursing job description revealed:</td>
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<td>**&quot;The Director of Nursing provides leadership, organization, planning, direction and</td>
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<td>administration of services toward the delivery of optimum resident care that is consistent with the</td>
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<td>established standards of nursing practice and the goals for a skilled nursing facility as part of the</td>
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<td>organization as a whole. Also, provides information and assistance to Administration regarding nursing</td>
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<td>related issues; ensures the delivery services and programs continues to respond to the needs of the</td>
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<td>residents while contributing to the financial stability of the facility.&quot;</td>
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<td>**Plans, organizes, directs and supervises the delivery of nursing care activities provided to the residents;</td>
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<td>directly or through delegation; in</td>
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accordance with organizational goals, federal and
state requirements, and other professional
standards, to ensure quality and continuity or
nursing/medical services."

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:

Surveyor: 40772

Based on observation, interview, record review,
and policy review, the provider failed to identify
and implement individualized interventions to
prevent:

*Facility acquired pressure ulcers from
developing for five of five sampled residents (9,
32, 45, 56, and 73).

*A blister from worsening and becoming a
pressure ulcer for one of one sampled resident
(52).

Findings include:

1. Review of resident 9's medical record
revealed:

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<td>686</td>
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<td>Treatment/Svcs to Prevent/Heal Pressure Ulcer</td>
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Corrective Action: 6/20/2019

DON/Designee reviewed and updated resident 9's care plan with individual and non-pharmacological interventions to prevent future facility acquired pressure ulcers including prevention with external medical devices, and an evaluation for air mattress. Registered Dietician assessed nutritional needs for wound healing on 6/5/2019. Wound care for current ulcers will continue daily with weekly measurements and evaluations and will include MD notification and orders changes as indicated. No immediate correction could be made for missing documentation on assessment for air mattress. The Brace/splint to hand was not added to care plan due to being discontinued. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

DON/Designee reviewed and updated resident 45's care plan with individual and non-pharmacological interventions.
Continued From page 19

*She had been admitted on 1/15/19.
*Her Brief Interview of Mental Status (BIMS) score was three indicating she had severe cognitive impairment.
*She had been admitted with a right wrist splint and right knee immobilizer.

Review of resident 9’s skin assessments between 1/15/19 and 5/21/19 revealed:
*1/15/19 she was admitted with a stage three pressure ulcer on her right butlock and a blister on her right rear thigh.
*1/29/19 both were healed.
*1/30/19 three wounds had been identified:
- Unstageable pressure ulcer between right thumb and fore finger.
- Stage two bister to the right upper thumb area.
- Suspected deep tissue injury to the right lower thumb.
*2/5/19 two additional pressure ulcers were identified on her right hand:
- Outside of the right little finger.
- Back of the right hand.
*2/12/19 two additional pressure ulcers were identified on her right outer ankle:
- One stage one.
- One stage two.
*2/19/19 a stage two pressure ulcer was identified on her right inner heel.
*2/26/19 all the above pressure injuries were healed.
*4/30/19 all stage two pressure ulcers were identified on her left butlock.
*5/7/19 "Area to left butlock is bigger. Resident has cushion to wheelchair. Is working with therapy so doesn’t always get laid down."
*5/14/19 she had completed wound care and an unstageable wound was found on her coccyx.
*5/21/19 two new suspected deep tissue injuries to prevent facility acquired pressure ulcers. Registered Dietician reviewed nutritional needs related to wound healing on 6/5/2019. Speech therapy is providing services for improvement in nutritional intake. Wound care for current ulcers will continue daily with weekly measurements and evacuations and will include MD notification and orders changes as indicated. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

DON/Designee reviewed and updated resident 73’s care plan with repositioning, gel cushion and individual and non-pharmacological interventions to prevent facility acquired pressure ulcers. Registered Dietician reviewed nutritional needs related to wound healing on 6/5/2019. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

DON/Designee reviewed and updated resident 56’s care plan with individual and non-pharmacological interventions to prevent facility acquired pressure ulcers, with new skin area concern from 5/21/2019 and repositioning and
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<td>F 686</td>
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- Left lower heel.
- Left upper heel.

Review of resident 9's 5/22/19 care plan revealed:
* There were no focus, goals, or interventions related to the brace/splint she had been admitted with on her right hand.
* She was identified to be at risk for skin breakdown on 1/15/19 and the interventions included:
  - Pressure reducing cushion to wheelchair (w/c) initiated on 1/18/19.
  - Weekly skin observations by a nurse initiated on 1/18/19.
  - Heel protector boots on both feet while in bed initiated on 5/21/19.
  - Pressure redistributing mattress on her bed initiated on 1/18/19.
  - Staff to monitor for potential skin breakdown initiated on 1/18/19.
  - Staff to lay her down between meals and reposition at least every two hours initiated on 5/6/19.

Multiple observations of resident 9 on 5/21/19 from 7:51 a.m. through 2:04 p.m. revealed:
* Resident wearing no heel boots while in bed.
* Resident wearing a heel boot only on her right foot in wheelchair and in bed.

Observation and interview on 5/21/19 at 04:23 p.m. with licensed practical nurse (LPN) J of resident 9 revealed:
* She had identified a circle about the size of a quarter on the inside of her left heel that was hard and unblanchable.
* She was unable to locate two heel boots in the off-loading her tailbone area.

Registered Dietician reviewed nutritional needs related to wound healing on 6/5/2019. No immediate corrective action could be made for Terry cloth left under resident on 5/21/2019. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

DON/designee reviewed and updated resident 62's care plan for individual and non-pharmacological interventions for prevention of facility acquired pressure ulcers. No immediate corrections could be made to prevent blister from becoming pressure ulcer. No immediate corrections could be made for staff not asking resident to offload heel with pillows or boots during cares provided on 5/21/2019 and 5/22/2019 as care plan indicated. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

DON/designee reviewed and updated resident 32's care plan for individual and non-pharmacological interventions for prevention of facility acquired pressure ulcers. All wounds have healed.
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<td>2200 13TH AVE BELLE FOURCHE, SD 57717</td>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded By Full Regulatory or LSC Identifying Information)</th>
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<th>Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced To The Appropriate Deficiency)</th>
<th>Completion Date</th>
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<td>F 686</td>
<td>Continued From page 21 resident's room when finished with her assessment. *She had verified the one heel boot on the right foot had been put on incorrectly. Multiple observations on 5/22/19 and 5/23/19 from 8:15 am through 8:00 p.m. resident 9 had been wearing two heel boots correctly. Interview on 5/23/19 at 8:16 a.m. with the medical director regarding her role in wound management revealed: *She assisted with identifying people at risk, their risk factors, and implementing preventative measures. *Sometimes it was hard to determine if a wound was preventable. -Sometimes they knew they should have been more on top of the risk factors. *How to manage wounds after they had developed. *Utilized the wound care clinic, physical therapy, occupational therapy, speech therapy and dietary. *Resident 9's hand wounds were related to the wrist splint. -Nursing was to notify the physician when the splint had been moved or was ill fitting. -She had never observed her messing with the sling. Interview on 5/23/19 at 9:08 AM with the director of nursing (DON) and administrator regarding resident 9's pressure ulcers revealed: -There was no documentation for evaluating her for a low air loss mattress. -All mattresses in the facility were pressure redistributing and were evaluated by the manufacture annually. -The expectation would be for her to have both Nutritional interventions continue to exceed needs for wound prevention. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable. Identification of others: DON/Designee will conduct a review of residents who have wounds to validate that care plans are appropriate and individualized with interventions and non-pharmacological interventions including turning and repositioning for prevention of facility acquired pressure ulcers, prevention of skin breakdown, and wound healing. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable. DON/Designee will conduct a review of residents who are at risk for pressure ulcers to validate that care plans are appropriate and individualized with interventions and non-pharmacological interventions including turning and repositioning for prevention of facility acquired pressure ulcers, prevention of skin breakdown, and wound healing. Resident, representative and physician were</td>
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| F 686 | Continued From page 22  
heel boots on at all times.  
2. Review of resident 45's medical record revealed:  
*She was admitted on 7/16/15.  
*Her BIMS score was zero indicating her cognition was severely impaired.  
*She required the extensive assistance of one staff member for bed mobility.  
*She required the extensive assistance of two staff members for transferring.  
Review of resident 45's weekly Pressure wound assessments from 4/21/19 through 5/21/19 revealed on:  
*4/21/19 four stage two pressure ulcers were identified.  
-Right buttock.  
-Left buttock.  
-Lower coccyx.  
-Upper coccyx.  
*4/23/19 right buttock pressure ulcer was healed.  
*4/30/19 all pressure ulcers were healed.  
*5/7/19 two pressure ulcers were identified.  
-Stage one on left outer ankle.  
-Stage two on right inner ankle.  
*5/14/19 she was seen by wound care and the pressure ulcers on her ankles were verified.  
Observation and interview on 5/21/19 at 1:45 p.m. of resident 45's pressure ulcers revealed:  
*Certified nursing assistant (CNA) O pointed out a spot on her left outer ankle that was painted with betadine.  
*She verified the resident had a pressure injury on her right inner ankle that was covered with a bandage.  
*She placed the resident's heel boots on after she was laid down in bed. |

<table>
<thead>
<tr>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 686 | notified. Any new orders were noted and care plan updated as applicable.  
Systemic Changes:  
Administrator, DON, IDT, and medical director reviewed and accepted facility's Wound Care Policy and procedure ensuring good assessment and identification, and prevention of potential and acquired pressure injuries/pressure ulcers with individualized interventions or approaches.  
DON/designee will educate licensed nurses on requirements of notifying resident, family, representative and physician on new wounds and status of wounds.  
DON/designee will provide education to nursing and dietary staff on requirements for providing and implementing interventions to prevent skin breakdown and promote wound healing.  
This education will be provided no later than 6/20/2019. Those who have not received education prior to 6/20/2019 will be educated prior to their next shift worked. |
Continued From page 23

Interview on 5/21/19 at 2:25 p.m. with resident 45's representative revealed:
*She did not know about the pressure ulcers on her heels.
*She did have a pressure ulcer on her buttock at one time.
 - She had been told they had healed the one on her buttock.

Review of resident 45's 5/22/19 care plan revealed:
*She was identified to be at risk of skin breakdown on 8/3/15.
*On 8/3/15 she required frequent reminders to shift her weight when she was sitting in her w/c.
 - Revised on 4/20/19.
*On 5/17/19 she needed to have a pillow between her knees and ankles to prevent her skin from rubbing on itself.
 - She also needed heel boots to off load her feet.
*On 4/24/19 a gel cushion was implemented for her w/c.
*On 10/24/16 she needed assistance to change positions every two hours.

Interview on 5/22/19 at 6:16 p.m. with the DON and administrator revealed:
*Roho cushion (pressure relieving) was put into place on 4/23/19, prior to gel cushion, initiated on 4/24/19.
 - Verified interventions were put into place after she had developed four pressure ulcers on her buttock.
*She would need to be assessed to know if she could off load herself.
 - She had needed less assistance when her care plan was developed.
*The administrator personally educated staff to

Monitoring/QAPI:

DON/Designee will conduct monitoring 3 times a week through chart review, observation and interview to ensure all appropriate interventions for prevention of skin breakdown and pressure ulcers and wound healing are implemented as appropriate.

DON/Designee will conduct monitoring 3 times a week through chart review, observation and interview to ensure resident, representative, and physician are notified timely of new wounds or changes in wound status.

DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 686</td>
<td>Continued From page 24 put pillows between her knees and ankles prior to the wound development. -She did that education on the day she was assessed to require a total body lift. (Date unknown) 3. Review of resident 73's medical record revealed: *She was admitted on 12/12/18. *Her BIMS score was thirteen indicating her cognition was intact. *She was totally dependent on two or more staff members for: -Transfers. -Bed mobility. Her weekly pressure wound assessments from 5/2/19-5/21/19 revealed on: *5/2/19 a stage two pressure ulcer was identified on her left buttock. -&quot;Will try off loading from buttocks when in bed.&quot; *5/14/19 the area was healed. *5/21/19 stage two pressure ulcer was identified on her coccyx. Interview on 5/21/19 at 9:48 a.m. with Resident 73 revealed she had developed a sore on her buttock since her admission. Observation on 5/22/19 at 10:40 a.m. of resident 73 revealed she was in w/c in her room with the Hoyer sling under her. Observation and interview on 5/22/19 at 2:07 PM with resident 73 revealed: *She was still sitting in her w/c. *She denied that she had been laid down, since getting up for therapy, after breakfast. *She was tearful and stated &quot;I am still in my damn chair&quot; when asked about repositioning.</td>
<td>F 686</td>
<td></td>
<td></td>
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</tbody>
</table>
**Continued From page 25**

Observation and Interview on 5/22/19 at 2:10 p.m. with resident 73 revealed:
*Two staff taking a total lift into her her room.*
*She was transferred into her recliner and staff left.*
*She indicated that at first her buttock hurt because of her pressure injuries.*
*When they began treatment for the pressure ulcers it was not as painful.*
*She tried to move around in her chair when her bottom would hurt.*
*She would lay in bed for long periods of time without assistance to reposition prior to her pressure injuries.*
*She started to get assistance with repositioning after her pressure injury developed.*

Interview on 5/22/19 at 4:51 p.m. with the DON and administrator regarding resident 73 revealed:
*Everyone who lives in the facility is to be repositioned every two hours unless specified otherwise.*
*It is standard for the resident to be repositioned every 2 hours even if she was in a w/c.*

Review of resident 73's 5/22/19 care plan revealed on 1/29/19:
*She was identified to be at risk for skin breakdown.*
*She had a pressure redistributing pad on her chair and mattress on her bed.*
*She was to have a skin assessment by a nurse weekly and staff were to monitor for potential skin breakdown.*
*There was no indication to assist resident with repositioning.*

Surveyor: 20162
4. Observation on 5/21/19 at 1:40 p.m. of LPN J
while she completed wound care for resident 56 revealed:
* The resident had a pressure relieving mattress on her bed and in her wheelchair.
* There had been a white terry cloth hand towel underneath the resident's buttocks.
  - LPN J:
    -- Asked the resident what it was for and she did not know.
    -- Left that wrinkled, terry cloth towel was left in place.
  * LPN J assisted the resident to position on her left side. She:
    - Removed the Optifoam gentle and looked at her buttocks.
    - Stated:
      -- There was a dark red area on her buttocks.
      -- It was slightly elevated and irritated.
      -- It extended upward from the resident's tailbone approximately four inches.
  - Completed the resident's treatment and had her onto her back.
  - Provided no care or additional interventions for the newly identified reddened skin area on the resident's tailbone.

Review of resident 55's care plan with a print date of 5/22/19 revealed:
* A focus area for a pressure wound.
* The newly identified skin area of 5/21/19 had not been identified on the current care plan.
* There had been no nonpharmacological interventions in place for the resident to assist her in repositioning and off loading her tailbone area.
* There had been one intervention that stated the resident refused pillows and staff assistance.
  - Observations on 5/21/19 from 9:00 a.m. through 12:00 p.m. and again from 1:15 p.m. through 5:00 p.m. revealed no staff had been observed asking
Continued From page 27

her if she wanted help to reposition.
Observation on 5/22/19 from 9:30 a.m. through 12:30 a.m. and again from 2:00 p.m. through 4:30 p.m. revealed no staff had been observed asking her if she wanted help to reposition.

Interview on 5/23/19 at 10:45 a.m. with the DON regarding resident 62's revealed she agreed:
"The wrinkled terry cloth towel should not have been left under her.
"The reddened area on her buttocks had required follow-up by LPN J.

5. Observation on 5/21/19 at 1:20 p.m. of LPN J while she completed a dressing change to resident 62's right heel revealed:
"The resident was sitting in her recliner.
"No pressure relieving device on or under her right heel.
"She removed the dressing from the resident's right heel.
"Used a compact mirror to view the wound on her heel.
"She stated "Oh, the blister has opened."
"Did not ask the resident or assist her to off load her right heel after the dressing change had been completed.

Review of the weekly wound and pressure assessments for resident 62 revealed LPN J documented:
"4/2/19 there had been a blister to the resident's right heel.
"4/9/19 the fluid filled blister had been unchanged.
"Area to right heel the blister had now popped. Area has separated at the upper edge flap intact. had moderate amount of drainage noted. will cover with optifoam no betadine to area if more
Continued From page 28

Drainage may start to use calcium alginate.*

*4/23/19 a note by LPN J stated "Resident blister broke open last week. Is dry no drainage noted."

*5/21/19 LPN J recorded "This presented as a fluid filled blister when admitted from hospital. Has been dry no fluid. Top of wound came off today with wound care. Area is bloody with serous [ ] drainage to area. Lower part of wound still has slough/echar to wound bed. Are covering with foam border dressing over area.

Review of resident 62's current care plan printed on 5/22/19 revealed:

A focus area for skin breakdown.

The interventions for the above areas had been "I am refusing foam boots, staff will continue to offer these. offer pillows to offload heels when in bed."

Observations on 5/21/19 from 9:00 a.m. through 12:00 p.m. and again from 1:15 p.m. through 5:00 p.m. revealed no staff had been observed asking her if she wanted help to reposition.

Observation on 5/22/19 from 9:30 a.m. through 12:30 a.m. and again from 2:00 p.m. through 4:30 p.m. revealed no staff had been observed asking her if she wanted help to reposition.

There had been no area of intervention that had been nonpharmacological on resident 62's care plan.

Interview on 5/22/19 at 10:30 a.m. with resident 62 revealed no staff ask her if she would like to off load her right heel while she is sitting in her recliner. She stated I don't always want to but they don't ask. I should have asked them.

Surveyor: 40053

6. Review of resident 32's 9/19/18 admission assessment Minimum Data Set (MDS) revealed:

*Her admission date was 9/12/18.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**K1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:**

435035

**K2) MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**K3) DATE SURVEY COMPLETED**

05/23/2019

**NAME OF PROVIDER OR SUPPLIER**

ROLLING HILLS HEALTHCARE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2200 13TH AVE

BELLE FOURCHE, SD 57717

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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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</thead>
</table>
| F 686 | Continued From page 29 | *Her 9/12/18 Braden scale assessment for predicting pressure sores was 13 indicating she was at moderate risk.  
*There was no Brief Interview for Mental Status (BIMS) assessment score due to significant cognitive impairment.  
*She required extensive assistance with a physical assist of one for:  
- Bed mobility.  
- Transfers.  
- Dressing.  
- Eating.  
- Toilet use.  
- Personal hygiene.  
*She was frequently incontinent of urine and bowel movements.  
*She was at risk for pressure ulcers (PU).  
*She had no healed PU’s.  
*She had interventions in place for a:  
- Pressure reducing device for her chair.  
- Pressure reducing device for her bed.  
* There was no hospice or respite care.  

Review of resident 32’s 12/18/18 quarterly MDS assessment revealed:  
*There was no Brief Interview for Mental Status (BIMS) assessment score due to significant cognitive impairment.  
*She was rarely understood.  
*She had a mechanically altered diet.  
*She required extensive assistance with a physical assist of two for:  
- Bed mobility.  
- Transfers.  
*She required extensive assistance with a physical assist of one for:  
- Dressing.  
- Eating.  
- Toilet use.  |
**Continued From page 30**

- Personal hygiene.
  * She was always incontinent of urine.
  * She was frequently incontinent of bowel movements.
  * She was on a mechanically altered diet.
  * She was at risk of PU's.
  * She had one unstageable PU due to non-removable dressing/device.
  * She had two unstageable PU with suspected deep tissue injury's.
  * She had interventions in place for e:
    - Pressure reducing device for her chair.
    - Pressure reducing device for her bed.
    - Nutrition or hydration intervention.
    - PU care.
  * There was no:
    - Turning or repositioning schedule.
    - No hospice or respite care.

Review of resident 32's 3/18/19 quarterly MDS assessment revealed:
  * There was no Brief Interview for Mental Status (BIMS) assessment score due to significant cognitive impairment.
  * She was rarely understood.
  * She had a mechanically altered diet.
  * She required extensive assistance with a physical assist of two for:
    - Bed mobility.
    - Transfers.
    - Dressing.
    - Eating.
    - Toilet use.
    - Personal hygiene.
  * She was frequently incontinent of urine and bowel movements.
  * She had no swallowing disorder.
  * She was on a mechanically altered diet.
  * She was at risk of PU's.
**continued from page 31**

*She had one stage two PU.
*She had one stage four PU.
*She had interventions in place for a:
  - Pressure reducing device for her chair.
  - Pressure reducing device for her bed.
  - Turning and repositioning schedule.
  - Nutrition or hydration intervention.
  - PU care.
  *There was no hospice or respite care.

Interview on 5/23/19 at 9:08 a.m. concerning resident 32 with the director of nursing and administrator revealed:
*The administrator meets with staff providing care.
*She made sure interventions were in place and being provided to residents.
*She stated resident 32 was on a repositioning schedule.
  - She expected everyone to reposition themselves if capable.
  *If unable to reposition themselves:
    - They would have contacted physical therapy (PT) and occupational therapy (OT).
    - Assessed for grab bars.
    - Put nutritional interventions into place.
  *She agreed there were no repositioning or foam boot interventions.
  *Stated even though there was no documentation, those interventions were done for everyone.
  *She agreed those interventions were not documented until after she developed PUs.

Interview on 5/23/19 09:48 a.m. with the Medical Director, her nurse, and the administrator concerning resident 32 revealed:
*She had dysphagia.
*She had spoken with the daughter and
**Department of Health and Human Services**

**Centers for Medicare & Medicaid Services**

**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/Clinic Identification Number:** 435635

**Building:**

**Wing:**

**Street Address, City, State, Zip Code:**
2206 13th Ave
Belle Fourche, SD 57717

**Date Survey Completed:** 05/23/2019

**ID Prefix Tag:**

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
</tr>
</thead>
</table>
| F 686         | Continued From page 32  
|               | - She was not to go to the hospital because of advancing;  
|               | - Dementia;  
|               | - Dysphagia.  
|               | * She was to have no feeding tube.  
|               | * She was not eating.  
|               | * PT and OT were involved for:  
|               | - A wheelchair cushion.  
|               | - The safest way to transfer her.  
|               | * Dietary was involved.  
|               | * There was a swallowing evaluation performed.  
|               | * The medical director stated with all the above in place she still developed a PU.  
|               | * The medical director believed the PU was unavoidable.  
|               | * She did agree there were other interventions that could have been in place proactively related to:  
|               | - Foam boots.  
|               | - Turning and repositioning schedule.  
|               | - Nutrition and hydration interventions.  
|               | * She agreed she did not have PUs when she was admitted.  
|               | * She agreed she was at moderate risk of developing PUs when admitted.  
|               | * The MD stated the resident's daughter agreed to sending her to wound care.  
|               | ** The facility did what they could to keep her comfortable and get her better.  
|               | * If you would have asked me I would have thought that she would be in hospice.  
|               | * Any PU on paper is unpreventable but you have to look at the person.  
|               | * She took a dip and now she is functioning better.*  
|               | Review of resident 32's weekly wound care documentation for a right heel wound revealed:  
|               | * Date of onset was 10/10/18.  

**ID Prefix Tag:** F 686
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
ROLLING HILLS HEALTHCARE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2200 13TH AVE
BELLE FOURCHE, SD 57717

**ID TAG**

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<tbody>
<tr>
<td>F 686</td>
<td>Continued From page 33</td>
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</tr>
<tr>
<td></td>
<td>*It was facility acquired (FA).</td>
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<tr>
<td></td>
<td>*A suspected deep tissue injury from 11/6/18 through 12/11/18.</td>
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<tr>
<td></td>
<td>*A stage one PU on 12/11/18.</td>
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<tr>
<td></td>
<td>*A stage one PU on 12/18/18.</td>
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</tr>
<tr>
<td></td>
<td>*Not staged on 12/24/18.</td>
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<tr>
<td></td>
<td>*A stage three PU on 12/28/18 and 2/5/19.</td>
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</table>

Review of resident 32's weekly wound care documentation for a left heel wound revealed:
*Date of onset was 12/11/18.
*It was FA.
*A PU on 11/6/18 was not staged.
*A stage three PU from 12/18/18 through 1/18/19.
*A suspected deep tissue injury on 1/15/19.
*A stage three PU from 1/22/18 through 1/26/19.
*A stage three PU from 2/12/19 through 2/19/19.
*A stage four PU from 2/26/19 through 3/5/19.
*A stage three PU on 3/5/19.
*A stage two PU from 3/12/19 through 4/02/19.

Review of resident 32's weekly wound care documentation for a right buttock wound revealed:
*Date of onset was 11/13/18.
*It was FA.
*A blister on 11/13/18.
*A stage one PU on 11/20/18.
*A suspected deep tissue injury from 11/27/18 through 12/4/18.
*An unstageable PU on 12/11/18.
*A stage four PU from 12/24/18 through 1/26/19.
*A stage four PU from 2/12/19 through 2/19/19.
*A stage three PU on 2/25/19.
*A stage four PU on 3/5/19 through 4/30/19.
*Progress note on 5/22/19 indicates weekly wound care has been completed.

Review of resident 32's weekly wound care
**Statement of Deficiencies and Plan of Correction**

**Providers/Supplier/CLA Identification Number:**

<table>
<thead>
<tr>
<th>(X1)</th>
<th>PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</th>
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<tbody>
<tr>
<td></td>
<td>435035</td>
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**Multiple Construction**

<table>
<thead>
<tr>
<th>(X2)</th>
<th>MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. BUILDING</td>
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<td>B. WING</td>
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</table>

**Date Survey Completed:**

<table>
<thead>
<tr>
<th>(X3)</th>
<th>DATE SURVEY COMPLETED</th>
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<td>C</td>
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<td>05/23/2019</td>
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</tbody>
</table>

**Name of Provider or Supplier:**

**Rolling Hills Healthcare**

**Street Address, City, State, Zip Code:**

2260 13TH AVE

**Belle Fourche, SD 57717**

**ID Prefix Tag**

<table>
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<tbody>
<tr>
<td>F 686</td>
<td>Continued From page 34 documentation for a left buttock wound revealed:</td>
</tr>
<tr>
<td></td>
<td>*Date of onset was 11/3/18.</td>
</tr>
<tr>
<td></td>
<td>*It was FA.</td>
</tr>
<tr>
<td></td>
<td>*Not stageable on 11/13/18.</td>
</tr>
<tr>
<td></td>
<td>*A stage two PU on 11/20/18.</td>
</tr>
<tr>
<td></td>
<td>*A stage four PU on 12/18/18, 12/23/18, and 2/6/19.</td>
</tr>
<tr>
<td></td>
<td>Review of resident 32's weekly wound care documentation for a sacrum wound revealed:</td>
</tr>
<tr>
<td></td>
<td>*It was FA.</td>
</tr>
<tr>
<td></td>
<td>*A stage two PU on 11/20/18.</td>
</tr>
<tr>
<td></td>
<td>Review of resident 32's weekly wound care documentation for a coccyx wound revealed:</td>
</tr>
<tr>
<td></td>
<td>*A stage two on 11/27/18.</td>
</tr>
<tr>
<td></td>
<td>*It was FA.</td>
</tr>
<tr>
<td></td>
<td>*Healed on 12/4/18.</td>
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<tr>
<td></td>
<td>*There was no other documentation given to this surveyor concerning this resident's wound care during the survey.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F 689</th>
<th>Free of Accident Hazards/Supervision/Devices CFR(§): 483.25(d)(1)(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS=D</td>
<td>§483.25(d) Accidents. The facility must ensure that -</td>
</tr>
<tr>
<td></td>
<td>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</td>
</tr>
<tr>
<td></td>
<td>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</td>
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<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by:</td>
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<tr>
<td></td>
<td>Surveyor: 40772</td>
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<tr>
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<td>Based on interview, record review, and policy review, the facility failed to ensure one of one</td>
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</tbody>
</table>

**ID Prefix Tag**

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 686</td>
<td>Corrective Action:</td>
</tr>
<tr>
<td></td>
<td>Therapy and DON reviewed and evaluated Resident 60 to determine the most comfortable and safe transfer to include evaluating for pain during transfers. Representative and physician were notified. Any new orders were noted and care plan updated as applicable.</td>
</tr>
<tr>
<td></td>
<td>Identification of others: DON/designee will conduct a review of residents to validate they are receiving safe and comfortable transfers and appropriate assistive devices are</td>
</tr>
</tbody>
</table>

**Completion Date:**

<table>
<thead>
<tr>
<th>(X4)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6/20/2019</td>
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</tbody>
</table>
Continued from page 35

sampled residents (60) who was totally dependant was transferred safely. Findings include:

Review of resident 60's 4/25/19 Minimum Data Set (MDS) assessment revealed:
* She was admitted on 7/17/17.
* Her Brief Interview for Mental Status (BIMS) score was zero indicating her cognition was severely impaired.
* She required the extensive assistance of two staff for:
  - Bed mobility.
  - Dressing.
  - Toilet use.
* She was totally dependent on two or more staff for transfers.

Interview of 5/21/19 at 8:51 a.m. with resident 60's representative revealed:
* She felt the lift used to transfer her mother caused pain.
* There were two men who worked in the evening who would help get her mother to bed.
  - She could not remember their names.
* She had asked them to pick her mother up and move her from the chair to the bed and vice versa.
* She had witnessed them moving her in this manner, without the lift and believed that it was easier on her mother.

Interview on 5/22/19 at 3:16 p.m. with certified nursing assistant (CNA) H regarding resident 60 revealed she:
* Required a full lift transfer.
* Denied seeing signs or symptoms of pain for the resident during transfer.
* Denied seeing anyone transfer her without a lift, utilized to prevent accidents.

Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

Systemic Changes:
Administrator/DON or designee will educate nursing and therapy staff on facility's Safe Lifting and Movement of Residents Policy. Education provided will include staff H and I.
Administrator/DON or designee will educate nursing and therapy staff on appropriate techniques and devices to lift and move residents to protect their safety and well-being and educate all mechanical lifting devices shall be used for heavy lifting and moving of residents. Education provided will include staff H and I.
Administrator/DON or designee will educate nursing and therapy staff on non-verbal signs of pain and staff roles and responsibilities if pain is observed during transfer of residents to include notification to nurse on duty, transfer assessment and/or therapy evaluations and physician notification.
This education will be provided no later than 6/20/2019. Those who have not received education prior to 6/20/2019 will be educated prior to their next shift worked.
**F 689** Continued From page 36 stating it would be unsafe.

Interview on 5/22/19 3:22 p.m. with CNA I regarding resident 60 revealed he had:
* Met resident 60's representative.
* Never seen or heard of anyone transferring her without a lift.
* Would not transfer the resident without a lift because it would jeopardize his job.

Interview of 5/22/19 at 2:41p.m. with the administrator and the director of nursing (DON) regarding resident 60 revealed:
* They would not be surprised if the family asked for the resident to be transferred without the lift.
* They would be surprised if the staff would transfer her without the lift.
* They had not heard of this happening.
* They did not transfer people without the total lift if they had been assessed to need the lift.

Review of provider's Qtr3, 2018 Safe Lifting and Movement of Residents policy revealed:
* The provider will use appropriate techniques and devices to lift and move residents to protect their safety and well-being.
* Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary.

**F 689** Monitoring/QAPI:
Administrator/DON or designee will conduct monitor 3 times a week through interviews and observation to validate residents are transferred safely and are pain free during transfer. Monitoring will randomly include resident 60 and staff H and I.
Administrator/DON or designee will conduct monitor 3 times a week through interviews and observation to validate residents are being transferred with the most appropriate technique and devices to lift and protect their safety and well-being. Monitoring will randomly include resident 60 and staff H and I.

**F 697** Pain Management
CFR(s): 483.25(k)

§483.25(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
**Corrective Action:**
The DON/designee reviewed and assessed Resident 56's pain management interventions with wound care and updated care plan with pain management related to wound care and surgical pain. No corrective action could be taken for wound care and pain management observed on 5/21/2019. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

**Identification of Others:**
The DON/designee will conduct a review of residents who exhibit signs of pain to validate appropriate and effective pain management. DON/Designee will conduct a review of residents care plans to ensure individualized and accurate interventions reflect pain management. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.

**Systemic Changes:**
Administrator/DON or designee will educate nursing staff on facility's Wound Care Policy to ensure residents are assessed for any special needs in...
continued from page 38

Give 1 tablet by mouth every 4 hours as needed for PAIN SCALE 8-10 OR 4-7 DO NOT EXCEED 60 MG/DAY Hold if RR rate <10 or sedated.

- LPN J had administered the above medication to the resident at 2:20 p.m.

- Roxycodone Tablet 5 MG (oxyCODONE HCL)

Give 2 tablet by mouth every 4 hours as needed for PAIN SCALE 8-10 OR 4-7 DO NOT EXCEED 60 MG/DAY Hold if RR rate <10 or sedated.

- LPN J had not administered two tablets of the pain medication pretreatment for the resident.

- She did not stop the treatment when the resident was in pain to provide her the additional pain medication.

*LPN J had administered the lowest dose of oxycodone to the resident for premedication prior to a painful treatment.

*LPN J stated the above was her usual practice for resident 56's wound care.

Review of resident 56's care plan printed on 5/22/19 revealed no mention of surgical pain management.

Interview on 5/23/19 at with the director of nursing regarding resident 56's pain management revealed LPN J should have:

* Attempted nonpharmacological methods of pain management during the treatment.

* Provided additional pain medication for resident 56 when she exhibited pain.

Review of the providers Qtr 3, 2018 Wound Care policy revealed:

**Review the resident's care plan to assess for any special needs of the resident.

**For example, the resident may have PRN (as needed) order for pain medication to be administered prior to wound [wound] care.**

relation to pain management with wound care treatments. Education will include assuring understanding to stop wound care until pain can be controlled with additional nonpharmacological and medication interventions are effective. Education will include notification to physician if pain is not controlled with interventions and medications. Education will include staff J.

This education will be provided no later than 6/20/2019. Those who have not received education prior to 6/20/2019 will be educated prior to their next shift worked.

Monitoring/QAPI:

DON/designee will conduct monitoring 3 times a week through chart review, observation and interview to validate that professional standards for pain management during wound care are provided, to validate that if pain is present, nonpharmacological interventions were attempted and/or pain medications was administered prior to wound care, to validate that wound care was stopped and pain was not controlled and physician was notified. Monitoring will randomly include resident 56 and
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<td>(X5) DATE SURVEY COMPLETED</td>
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<td>SS=D</td>
<td>Provision of Medically Related Social Service CFR(s): 483.40(d)</td>
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<td>§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:</td>
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<td>Surveyor: 40772</td>
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<td>Based on interview and record review the provider failed to ensure:</td>
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<td>1. One of one sampled residents had a complete and documented discharge plan.</td>
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<td>2. One of one sampled residents had support in the transition from rehabilitation to long term care.</td>
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<td>Findings include:</td>
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<td>1. Review of resident 9's 5/3/19 Minimum Data Set (MDS) assessment revealed:</td>
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<td>*Her admit date was 4/22/19.</td>
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<td>*Her Brief Interview for Mental Status (BIMS) score was a three indicating she was severely cognitively impaired.</td>
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<td>*Her family participated in the assessment and no discharge expectation was identified.</td>
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<td>Interview on 5/21/19 at 2:20 p.m. with resident 9's representative revealed:</td>
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<td>*He lived an hour away from the facility and would like for her to be closer.</td>
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<td>*It was hard for him and other family to visit due to the distance.</td>
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<td>*He did not feel he was getting much help from the provider to find a closer placement for her.</td>
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<td>Interview on 5/23/19 at 10:20 a.m. with the social services designee (SSD) regarding resident 9's discharge plan revealed:</td>
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<td>*She was aware the resident's representative</td>
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<td>F 745</td>
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<td>staff J.</td>
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<td>DON or designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.</td>
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<td>Corrective Action:</td>
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<td>Social Service Director reviewed and validated resident 9's care plan was updated to identify which facilities discharge referrals have been made to and discharge plans have been documented in the residents medical record. No corrective action could be taken for absence of documentation of prior referral efforts and follow-up calls. A complete and documented discharge plan has been established.</td>
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<td>Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.</td>
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|           |     | Social Service Director reviewed and validated Resident 23 for physical, mental and psychosocial well-being to include evaluation of psychological therapy related to moving from rehabilitation to long term care and care plan was updated with goals and interventions related to mood and behavior. Resident, representative and
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
ROLLING HILLS HEALTHCARE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
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BELLE FOURCHE, SD 57717

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| F 745         | physician were notified. Any new orders were noted and care plan updated as applicable. Identification of Others:
Social Service Director or designee will conduct a review of residents to validate complete and documented discharge plans are in the medical record and updated on care plans.
Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.
Social Service Director or designee will conduct a review of residents to validate appropriate interventions are indicated for physical, mental and psychosocial well-being and if indicated, a referral for psychological therapy services are offered. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.
Systemic Changes:
Administrator will educate Social Service staff on facility’s D/C Summary and Plan Policy to ensure residents have complete and documented discharge plans and are offered psychological therapy if indicated during assessment.
This education will be provided no later.

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Social Service Director or designee will conduct a review of residents to validate appropriate interventions are indicated for physical, mental and psychosocial well-being and if indicated, a referral for psychological therapy services are offered. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.
Systemic Changes:
Administrator will educate Social Service staff on facility’s D/C Summary and Plan Policy to ensure residents have complete and documented discharge plans and are offered psychological therapy if indicated during assessment.
This education will be provided no later.

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Social Service Director or designee will conduct a review of residents to validate complete and documented discharge plans are in the medical record and updated on care plans.
Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.
Social Service Director or designee will conduct a review of residents to validate appropriate interventions are indicated for physical, mental and psychosocial well-being and if indicated, a referral for psychological therapy services are offered. Resident, representative and physician were notified. Any new orders were noted and care plan updated as applicable.
Systemic Changes:
Administrator will educate Social Service staff on facility’s D/C Summary and Plan Policy to ensure residents have complete and documented discharge plans and are offered psychological therapy if indicated during assessment.
This education will be provided no later.
**F 745** Continued From page 41

*She had a diagnosis of depression.  
*She had received an antidepressant seven of seven days in the assessment look back period.  
*She has received no psychological therapy.

Interview on 5/21/19 at 11:36 a.m. with resident 23 revealed:  
*She indicated she was sad often.  
*She had a history of feeling sad for a long periods of time.  
*Her affect was very flat when talking with her.

Interview on 5/23/19 at 10:41 a.m. with the SSD regarding resident 23 revealed:  
*She was aware of resident 23's flat affect.  
*She had been informed by the family that historically she had a flat affect.  
*She agreed that with moving from assisted living to rehabilitation to long term care was a great loss for the resident.  
*She stated "I should probably offer Deer Oaks", which is a therapy service.

Review of resident 23's 3/15/19 care plan revealed there were no goals or interventions related to her mood or behavior.

**F 746**

than 6/20/2019, Those who have not received education prior to 6/20/2019 will be educated prior to their next shift worked.

Monitoring/QAPI:  
Administrator or designee will conduct monitoring weekly to validate appropriate and complete discharge plans are in place and documented on care plan and in medical record, to ensure referrals are continued and documented and efforts are communicated to resident and/or representative. Monitoring will randomly include resident 9.  
Administrator or designee will conduct monitoring weekly to validate residents are supported in transition to long term care, to validate residents are evaluated for physical, mental and psychosocial well-being, to validate psychological therapy is offered if indicated, to validate goals and interventions related to mood and behavior are documented on the care plan.  
Monitoring will randomly include resident 23.  
Administrator will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.

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**F 866**

QAA Committee  
CFR(s): 483.75(g)(1)(ii)-(iii)(2)(i)

§483.75(g) Quality assessment and assurance.  
§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:  
(i) The director of nursing services;  
(ii) The Medical Director or his/her designee;  
(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other
**NAME OF PROVIDER OR SUPPLIER**

ROLLING HILLS HEALTHCARE

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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| F 868 | Continued From page 42  
individual in a leadership role;  
§483.75(g)(2) The quality assessment and assurance committee must:  
(1) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary.  
This REQUIREMENT is not met as evidenced by:  
Surveyor: 29162  
Based on interview, record review, observation, and policy review, the provider failed to ensure an effective quality assurance and performance Improvement (QAPI) program had been implemented to identify and address concerns related to residents' care within the facility.  
Findings include:  
1. Interview on 5/23/19 at 11:45 a.m. with the administrator regarding the QAPI program revealed:  
*The committee met monthly.  
*The medical director attended most months  
*She had identified a problem with facility acquired pressure ulcers.  
-Started an Action Plan but had not fully implemented it.  
-The action plan had no implementation date or measurable goals.  
*They had not identified all the areas of concern identified during this recertification survey.  
*They had no performance improvement plans (PIP) in place right now.  
Review of the provider's undated Quality Assurance and Performance Improvement (QAPI) policy revealed:  
**Purpose Statement: Our organizations written  
Corrective Actions:  
Administrator reviewed and updated Quality Assessment and Assurance Committee to include the following areas of concern: Resident Rights/Dignity, Care Plan, Quality of Care, Pressure Ulcer Prevention, Accident/Hazards/Supervision/Devices, Pain Management, Residents requiring medically related Social Services and discharge planning, Infection prevention and control.  
Administrator and DON reviewed, updated and implemented a Pressure Ulcer Action Plan/Performance Improvement Plan to include prevention of pressure ulcers, implementation date and measurable goals.  
Identification of Others:  
Administrator/DON have reviewed areas of concern through observation, interview and chart reviews of residents residing in facility. QAA template will be updated to include data from state and national sources for comparison.  
Systemic Changes:  
Administrator has reviewed QAA template and plan and facility’s Quality Assurance and Performance Improvement Policy. |

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| F 868 | Corrective Actions:  
Administrator reviewed and updated Quality Assessment and Assurance Committee to include the following areas of concern: Resident Rights/Dignity, Care Plan, Quality of Care, Pressure Ulcer Prevention, Accident/Hazards/Supervision/Devices, Pain Management, Residents requiring medically related Social Services and discharge planning, Infection prevention and control.  
Administrator and DON reviewed, updated and implemented a Pressure Ulcer Action Plan/Performance Improvement Plan to include prevention of pressure ulcers, implementation date and measurable goals.  
Identification of Others:  
Administrator/DON have reviewed areas of concern through observation, interview and chart reviews of residents residing in facility. QAA template will be updated to include data from state and national sources for comparison.  
Systemic Changes:  
Administrator has reviewed QAA template and plan and facility’s Quality Assurance and Performance Improvement Policy. | 6/20/2019 |
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<td>Administrator will educate all members of QAA of the updated plan and and their roles and responsibilities of monitoring areas addressed to promote excellence in quality of care, quality of life, resident choice, person directed care, and resident transitions to include monitoring of resident and family satisfaction. This education will be provided no later than 6/20/2019. Those who have not received education prior to 6/20/2019 will be educated prior to their next shift worked. Monitoring/QAPI: Administrator will conduct monitoring monthly to ensure areas of concern regarding facility operations and resident care are identified and addressed thoroughly through QAA. Monitoring will include validating Action Plan/PIP are implemented as indicated with implementation dates and measurable goals and data is being discussed at QAA. Administrator will report any identified trends to the Quality Assurance Committee monthly and as needed until a lesser frequency is deemed appropriate.</td>
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<td>Infection Prevention &amp; Control</td>
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<td>§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.</td>
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<td>$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:</td>
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<td>Corrective Action: Administrator/Therapy Director or designee reviewed and validated all therapy equipment was cleaned and sanitized, validated all resident equipment was cleaned and sanitized. Administrator/DON or designee reviewed and validated all single use items were disposed of and new items obtained, validated a sign was placed on resident 53’s door indicating isolation precautions and alerting others of precautions. No immediate corrective action could be taken for improper use of Micro Kill Bleach wipe on 5/21/2019. No immediate corrective action could be made for catheter bag being placed on therapy room floor on 5/21/2019. No immediate corrective action could be taken for improper hand hygiene performed by staff H, K, L, M and F on 5/20/2019, 5/21/2019, 5/22/2019 and 5/23/2019. No immediate corrective action could be made for improper hand hygiene while preparing food on 5/21/2019 by staff Y. Residents 72 and 24 are unknown, no immediate corrective action could be taken. Identification of Others: DON or designee reviewed all residents.</td>
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<td>F 880</td>
<td>Continued From page 45 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. §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: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed the ensure infection control practices were followed for: *Cleaning of therapy equipment between resident use by one of one certified occupational therapy assistant (COTA) W. *Cleaning and sanitizing of equipment between resident use and disposal of single use items by licensed practical nurse (LPN) (J) following wound care for residents 32 and 56. *Use of the Micro Kill Bleach wipes had been used effectively for one of one resident (128) by one certified nurse aide (CNA) (V) observed. *Catheter bag placement for one of one observed resident (129). *Personal protective equipment (PPE) had been used correctly by CNA (T) and two unidentified CNAs.</td>
<td>F 880</td>
<td>on isolation and validated those on isolation precautions have a sign placed on their doors indicated isolation precautions and alerting others of precautions required. Administrator/Therapy Director reviewed all resident use equipment and supplies to validate residents are using equipment and supplies that are cleanable. Systemic Changes: Administrator, DON, IDT and medical director reviewed and accepted Infection Control and Prevention Policy and procedures, Resident Care Items and Equipment Policy and Handwashing/Hand Hygiene Policy and procedure to ensure appropriate infection prevention and control. Administrator and Director of Rehab will educate therapy staff on their roles and responsibilities regarding the Resident Care Items and Equipment Policy to ensure proper cleaning and sanitizing all equipment and supplies used by residents after use. Education will include ensuring urinary drainage bags are not placed on floors. Administrator/DON or designee will educate nursing staff on their roles and responsibilities regarding the Resident Care Items and Equipment Policy to ensure proper disposal of single</td>
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<td>F 880</td>
<td>use and contaminated items including wound car supplies not being placed on unclean surfaces. Education will include proper cleaning and sanitizing reusable resident products and equipment. Education will include Micro Kill Bleach wipes guideline for wet time of thirty seconds. Education will include ensuring urinary drainage bags are not placed on floors. Administrator/DON or designee will educate nursing, therapy, maintenance, dietary, activities and housekeeping/laundry staff on their roles and responsibilities regarding the facility’s Isolation Categories of Transmission-Based Precautions Policy and procedure and Handwashing/Hand Hygiene policy and procedure to validate proper hand hygiene before, during and after entering and leaving an isolation room. Education will include proper disposal of items removed from an isolation room, ensuring items removed from rooms are separate from clean and new items to be placed in rooms. Education will include proper use of Personal Protective Equipment and ensuring contaminated supplies are not placed on clean surfaces or near food. Education will include proper handwashing/hand hygiene before</td>
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<td>* Hand hygiene had been completed by CNAs H, K, L, and M, and by registered nurse (RN) (L) and (F).</td>
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<td>* Cook Y had completed hand hygiene at appropriate times while preparing food during one of two meal preparation observations. Findings include:</td>
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<td>1. Observation on 5/21/19 at 9:28 a.m. of COTA W while he worked with two random residents revealed:</td>
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<td>* He used clothes pin clips with the first resident.</td>
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<td>* With the second resident he used cones and a ball and stick.</td>
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<td>* The ball and stick and clips were put directly in the supply cupboard after use without cleaning or sanitizing.</td>
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<td>Observation and interview on 5/23/19 at 9:33 AM with the COTA W while he worked with resident 125 revealed:</td>
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<td>* He used pegs and a peg board with the resident.</td>
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<td></td>
<td>* He put the equipment directly back into the supply cupboard without cleaning or sanitizing them.</td>
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<td>* Stated he usually wiped off the equipment after use but forgot to sometimes.</td>
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<td>* Agreed the equipment should have been cleaned after use with each individual resident.</td>
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<td>Interview on 5/23/19 at 10:07 AM with the director of physical therapy revealed he expected the resident use equipment to have been sanitized after use and before putting it away.</td>
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<td>Interview on 5/23/19 at 3:07 p.m. with the director of nurses revealed she expected RN F to have washed her hands when changing gloves from soiled to clean. She agreed the supplies used for</td>
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Continued From page 47
the resident's wound care should not have been laid on the unclean beside table or bed sheet.

2. Observation on 6/24/19 from 1:20 p.m. through 1:40 revealed she:
   * Used two paper single-use measuring tape strips to measure resident 58's wounds.
   * Used two paper single-use measuring strips to measure resident 62's wounds.
   * Used a compact pocket mirror to view and measure resident 62's heel wound.
   * Used her pocket sanitizer and rubbed it on the outside of the compact mirror.
   * Put all the paper measuring tapes she had used on the nurse’s desk.
   - That desk had papers, cups, pens, and pencils laying on it.

   Interview on 5/23/19 at 3:07 p.m. revealed she agreed:
   * The paper measuring tapes should have been disposed of, not placed at the nurse's station.
   * Hand sanitizer had not been the correct product to use on the compact mirror.

   Review of the provider's revised July 2014 Cleaning and disinfection of Resident-Care Items and Equipment revealed:
   * Single use items were to have been disposed of.
   * Reusable resident care equipment was to have been cleaned and disinfected before reuse by another resident.
   * Intermediate or low-level disinfectants for non-critical items included:
     - Ethyl or isopropyl alcohol.
     - Sodium hypochlorite (5.25-8.15% diluted 1:500 or per manufacturer's instructions).

3. Observation on 5/24/19 of CNA V while she during and after direct contact with residents and before and after applying and removing gloves, to prevent the spread of infection to other residents, personnel, visitors and will include appropriate use of alcohol-based hand rub and soap and water. Education will include staff W, J, V, T, H, K, L, M, F, Y.

Staff PTA A is unknown - all therapy staff will be educated.
This education will be provided no later than 6/20/2019. Those who have not received education prior to 6/20/2019 will be educated prior to their next shift worked.

Monitoring/QAPI:
Administrator/DON or designee will conduct monitoring 3 times a week to validate the following:
Therapy Equipment and supplies are cleaned and sanitized between residents or after use
Isolation rooms have a sign posted alerting staff and others of precautions
Dietary staff conduct proper hand washing during food handling
Proper handwashing/hygiene before and after glove use, between soiled and clean gloves, before entering and leaving a resident room, before providing cares
Continued from page 48

cleaned bowel movement and urine from the floor revealed she:
*Wiped it up with dry cloth.
*Then wiped the same area with a cloth wet with water.
*Wiped the same area with Micro Kill Bleach wipes.
*Immediately dried the area she had wiped with the wipes.
*Stated "I dry it right away."
*Had been unsure if there had been a wet time for effectiveness of the Micro Kill Bleach wipes.

Review of the Micro Kill Bleach wipes package revealed the surface contact wet time was thirty seconds.

Interview on 5/23/19 at 3:30 p.m. with the DON revealed her expectation was to follow the manufacturer's direction on the package.

4. Observation on 5/21/19 at 3:23 p.m. of resident 125 while sitting in a chair in the therapy room revealed revealed her indwelling catheter straight drainage bag was laying directly on the floor underneath her chair. Interview with PTA A and CNA U at that time revealed that was usual practice in the therapy room.

Interview on 5/23/19 at 3:15 p.m. with the DON revealed she agreed the urinary drainage bag should not have been on the floor.

Surveyor: 41088
5. Observation on 5/20/19 at 5:56 p.m. of resident 53's room. CNA's were entering the room wearing gowns and gloves. There had been no sign on the door to alert others of contact precautions.

Wound care supplies are kept sanitary prior to application
Proper cleaning of re-usable resident and staff equipment
Proper disposal of single use items
Staff competency of Micro Kill Bleach wipes
Catheter bags are covered and not placed directly on floor
Staff competency and effective use of PPE in isolation rooms
Contaminated dishes/cups are separated from clean dishes/cups
Monitoring will randomly include residents 32, 56, 128, 125, 53, 66, 52, 73 and staff W, J, V, T, H, K, L, M, F, Y U.
Resident 72, 24 and staff PTA A are unknown.

Administrator/DON or designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>F 880</td>
<td>Continued From page 49</td>
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<tr>
<td></td>
<td>Interview on 5/21/19 at 2:21 p.m. with DON regarding resident 53 revealed:</td>
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<tr>
<td></td>
<td>*Staff were to follow contact precautions by gowning and gloving prior to entering his room.</td>
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<td></td>
<td>*After care staff should have taken off gown and gloves and placed them into the garbage receptacle before exiting the room.</td>
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<td></td>
<td>*Staff should have been aware of contact precautions that were in place for him due to personal protective equipment (PPE) being outside of the room. The staff should have known to gown and glove when they saw the PPE outside the doorway.</td>
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<tr>
<td></td>
<td>*The DON stated he had no visitors that needed to be informed of the precautions in place.</td>
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<td>*Volunteers would have known about the precautions in place without the need for a sign.</td>
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<td>Observation on 5/21/19 of restorative aide, CNA T at 8:46 a.m. revealed she had:</td>
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<td>*Walked next to resident 53 returning from a therapy session.</td>
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<td>*Assisted him into his room and into his recliner without putting on gown and gloves.</td>
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<td></td>
<td>*Not followed contact precautions prior to entering his room or performed hand hygiene prior to leaving.</td>
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<td>Interview on 5/22/19 at 8:49 a.m. with restorative aide T revealed:</td>
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<tr>
<td></td>
<td>*She was aware she had not gowned or gloved prior to entering his room.</td>
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<td></td>
<td>*She had not followed contact precautions that had been in place.</td>
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<td></td>
<td>*She stated they usually had gowned and gloved prior to entering his room.</td>
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<td></td>
<td>Interview on 5/23/19 with the DON at 10:08 a.m. revealed:</td>
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<td>*Contact precautions had been discontinued on</td>
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<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLIANCE DATE</th>
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<tr>
<td>F 880</td>
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</table>
**F 880** Continued From page 50  
3/15/19.  
*Acknowledged staff had continued to follow precautions even though the order was discontinued.  
*A new order had been obtained on 5/21/19 for contact precautions to begin.  

Review of resident 53's medical record revealed:  
*He had been admitted on 1/22/18.  
*His diagnoses were: Type 2 diabetes mellitus with foot ulcer, paroxysmal atrial fibrillation, end stage renal disease, and non-pressure chronic ulcer of right heel and midfoot with unspecified severity.  
*His history included an infection extended spectrum beta lactamase (ESBL) since 11/2/18.  
*Contact precautions were initiated on 11/2/18.  
*On 3/11/19 a pressure ulcer was identified on his left calf.  

Review of resident 53’s 3/15/19 care plan revealed:  
*Contact precautions had been discontinued on 3/15/19.  
-Staff had continued to follow contact precaution practices.  

A physician order was obtained on 5/21/19 for contact precautions after the surveyor brought up resident 53’s history of ESBL.  

Review of the provider’s dated Quarter 3, 2018 Isolation Categories of Transmission-Based Precautions policy and procedure revealed:  
*Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others.  
*Implement contact precautions for residents
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<tr>
<th>ID</th>
<th>PREFIX</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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| F 880 |        |     | Continued From page 51 known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment." Surveyor: 40053 6. Observation on 5/20/19 at 3:41 p.m. of LPN J entering resident 66's room revealed: *The resident was on contact precautions. *Without performing hand hygiene LPN J put on a gown and gloves. *She placed the catheter cover over the catheter bag and hung it on the bed. *She removed her gown and gloves in the room. *She placed those items into an approximately two-and-a-half foot high contamination box. *She used hand foam and left the room. Observation on 5/20/19 at 3:48 p.m. of LPN J entering resident 66's room revealed: *The resident was on contact precautions. *Without performing hand hygiene, LPN J put on a gown and gloves. *She checked the catheter strap. *It was secure. *She removed her gown and gloves in the room. *She placed those items into an approximately two-and-a-half foot high contamination box. *She used hand foam and left the room. Interview on 5/22/19 at 3:53 p.m. with LPN J concerning the above observation revealed: *She agreed she had not performed hand hygiene either time before putting on her gloves and entering the room. *She stated there were no foam sanitizer's in the hallway to use. *She should have used the sink in the activities room to wash her hands prior to gloving.
F 880 Continued From page 52

- The activity room was approximately ten feet away.
  *She stated every room has foam sanitizer.
  -She was unable to use the foam sanitizer because she needed to gown and glove up before entering

7. Observation and Interview on 5/20/19 at 4:19 p.m. with CNA K in resident 72's room revealed:
  *He went into her room.
  *Without hand hygiene he:
    -Placed resident into the EZ stand.
    -Moved her into her bathroom.
  *Without hand hygiene he:
  -Put on gloves.
  -Pulled down her pants.
  -Removed her brief and placed it in the trash can.
  -Removed his gloves.
  *Without hand hygiene he:
  -Put new gloves on.
  -Lowered resident onto the toilet.
  -Put a new brief around her legs.
  -Moved her wheelchair.
  -Picked up the room.
  -Removed his gloves.
  *Used hand sanitizer and put on gloves.
  *Rased the resident from the toilet with the EZ stand.
  *Wiped her.
  *With the same gloved hands he:
    -Pulled up her brief.
    -Pulled up her pants.
  *He removed his gloves.
  *Without hand hygiene he:
    -Lowed the resident into her wheelchair using the EZ stand.
  *When questioned about his hand hygiene CNA K stated:
    -I should have performed hand hygiene before
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLIANCE DATE</th>
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<tr>
<td>F 880</td>
<td></td>
<td>Continued From page 53 going into her room. -I should have performed hand hygiene after removing my gloves.</td>
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<td>8.</td>
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<td>Observation and interview on 5/20/19 at 4:37 p.m. of CNA K in resident 24’s room revealed:</td>
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<td>He helped the resident into her wheelchair and into her bathroom.</td>
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<td></td>
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<td>He helped her stand.</td>
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<td>Without putting on gloves he:</td>
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<td>Pulled her pants down.</td>
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<td></td>
<td>Pulled her brief down.</td>
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<td>Left the resident on the toilet and without washing his hands:</td>
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<td></td>
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<td>Straightens out her bed.</td>
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<td></td>
<td>Cleans up around her room.</td>
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<td>Helped resident out of the bathroom.</td>
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<td>Used hand sanitizer and left the room.</td>
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<td>When questioned about his hand hygiene CNA K stated:</td>
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<td>He did not use good hand hygiene.</td>
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<td>He gets busy.</td>
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<td>Had a lot of call lights and residents to get to.</td>
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<td>Should have used more hand hygiene.</td>
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<td>9.</td>
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<td>Observation on 05/21/19 at 7:41 a.m. of resident 52 during a brief change revealed:</td>
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<td>RN L was called into the room.</td>
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<td>She had been asked to view the residents skin.</td>
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<td>Without washing or sanitizing her hands she put on gloves.</td>
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<td>She looked at the residents skin concern.</td>
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<td>She removed her gloves.</td>
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<td>She used the foam sanitizer and left the room.</td>
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<td>Surveyor 29162. Observation on 5/23/19 12:49 PM of RN F while she completed wound care for resident 73</td>
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<td>revealed she:</td>
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<td>Changed her gloves from soiled to clean five</td>
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times. She did not complete hand hygiene any of those five times.

Interview on 5/23/19 at 3:07 p.m. with the director of nurses revealed she expected RN F to have washed her hands when changing gloves from soiled to clean. She agreed the supplies used for the resident's wound care should not have been laid on the unclean beside table or bed sheet.

10. Observation on 5/21/19 at 4:06 p.m. of CNA K delivering fresh ice water in bubble cups to residents revealed:

*Without wash his hands he put on a gown and gloves.

*He took a new bubble cup into the room.

*He removed his gown and gloves in the room.

*He placed those items into an approximately two-and-a-half foot high contamination box.

*He used foam sanitizer and left the room.

*He had the used bubble cup from the room in his hand.

*He placed that bubble cup on the bottom shelf of the metal cart.

*There were other used cups on that shelf.

*The metal cart held:

-Bubble cups filled with fresh water and ice.

-A square container of snacks.

-Ice and soda's.

*He took the cart into the bistro serving area.

*He delivered two of those soda's to resident's in the open court area.

*He placed the unused bubble cups of water and soda's into the fridge.

*He placed the unused snacks into the cabinet.

*He left all the used bubble cups on the cart.

*He left the bistro area and used a sink outside of that area to wash his hands.
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<th>F 880</th>
<th>Continued From page 55</th>
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<tbody>
<tr>
<td></td>
<td>11. Observation and interview on 5/22/19 at 1:18 p.m. of CNA M, in resident 52's room revealed:</td>
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<td></td>
<td>*CNA M walked into the room.</td>
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<td>*She noticed the wet area on the floor and to the resident's sweat pants.</td>
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<td></td>
<td>*She stated she had offered to lay her down at approximately 10:00 a.m. so she could change her brief.</td>
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<td></td>
<td>-The resident had refused.</td>
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<td></td>
<td>*She used her Walkie Talkie to ask for assistance to the room.</td>
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<td>*She left and returned with a mop and bucket.</td>
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<td></td>
<td>*She mopped up the wet area on the floor to the rear of the w/c.</td>
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<td>*She picked the bubble cup up from the floor.</td>
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<td>-She placed it onto the residents over-the-bed table.</td>
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<td></td>
<td>-It was next to her lunch tray.</td>
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<td>-It was put next to her other two bubble cups.</td>
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<td></td>
<td>-There was now a total of three bubble cups next to her lunch.</td>
</tr>
<tr>
<td></td>
<td>--Two filled with an orange liquid.</td>
</tr>
<tr>
<td></td>
<td>--One with a brown liquid.</td>
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<tr>
<td></td>
<td>*She went into the bathroom and without washing her hands she put on gloves.</td>
</tr>
<tr>
<td></td>
<td>*At 1:38 p.m. CNA M removed her gloves.</td>
</tr>
<tr>
<td></td>
<td>-She did not perform any hand hygiene.</td>
</tr>
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<td></td>
<td>-She left the room.</td>
</tr>
</tbody>
</table>

12. Interview on 5/23/19 at 12:40 p.m. with the administrator concerning the above observations in findings 6, 7, 8, 9, 10, and 11 revealed:  
*The employees had their own hand sanitizer.  
*They could use their hand sanitizer or the foam sanitizer in the rooms.  
*They needed to perform hand hygiene:  
-Going into or out of a room.  
-Before putting on gloves.  
-After removing gloves.
**Continued From page 56**

Surveyor: 40772

13. Observation and interview on 5/21/19 from 11:15 a.m. to 11:43 a.m. of cock KY revealed:
*She took the temperature of the chicken to ensure that it was hot enough to serve.
*She cut the chicken into smaller pieces to grind.
*She had gone into the refrigerator to get cheese to add to the chicken.
*She had opened the cupboard to get a plastic spoon, which she used to check consistency of the chicken.
*She got a metal pan, sprayed it with cooking spray and transferred the ground chicken into it.
*She added more chicken to the grinder and began the puree process.
*She was taking the lid on and off the grinder to check the consistency of the chicken.
*She went to get another metal pan, sprayed it with cooking spray and transferred the pureed food into it.
*She put on oven mitts and picked up a pan of boiling vegetables.
*She poured the vegetables into the blender and began to puree them.
*She was adding slices of bread into the blender of vegetables with her bare hands.
*She went to get another metal pan, sprayed it with cooking spray and then transferred the vegetables into it.
*She covered the chicken and vegetables with foil and placed the pans into the oven after putting on oven mitts.
*She got the rice that was cooking on the stove and added it to another blender to be pureed.
*She went to the dining room three times to get hot water from the coffee dispenser to add to the rice.
*She got into the cupboard again to get a plastic spoon to check the consistency of the rice.
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
</table>
| F 880             | Continued From page 57
| *She went to get another metal pan, sprayed it with cooking spray and added the rice to it.*  
*She covered it with foil and added it to the oven.*  
*There was no observation of hand hygiene during this process.*  

Interview on 5/23/19 at 10:02 a.m. with the certified dietary manager and the dietician verified that cook Y had missed some opportunities for hand hygiene in her food preparation on 5/21/19.

Review of the provider last revised August 2015 Handwashing/Hand Hygiene policy revealed:  
*All personnel were to have followed the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors.*  
*An alcohol-based hand rub or soap and water was to have been used:*  
- Before and after direct contact with residents.  
- After removing gloves.
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/Clinical Laboratory
IDENTIFICATION NUMBER:
435035

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED
05/23/2019

NAME OF PROVIDER OR SUPPLIER
ROLLING HILLS HEALTHCARE

STREET ADDRESS, CITY, STATE, ZIP CODE
2220 13TH AVE
BELLE FOURCHE, SD 57717

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

E 000 Initial Comments

Surveyor: 29162
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 from 5/20/19
through 5/23/19. Rolling Hills Healthcare was
found in compliance.

E 000

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

Thomood

TITLE
Administrator

(99) DATE
6/17/19

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 are in place and the patient is not placed in danger. (See instructions.) Except for nursing homes, the findings stated above are discloseable 90 days following the initial survey with or without a plan of correction provided. For nursing homes, the above findings and plans of correction are discloseable 64 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.

F0M CMS-257 (02/19) Previous Versions Obsolete

Event ID: LF7K11
Facility ID: 6012

If continuation sheet Page 1 of 1
**K 000  INITIAL COMMENTS**

Surveyor: 20031
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/21/19. Rolling Hills Healthcare was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.

The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

**K 712  Fire Drills**

**SS=F**

CFR(s): NFPA 101

Fire Drills
Fire drills include the transmission of a fire alarm signal and activation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.

19.7.1.4 through 19.7.1.7
This REQUIREMENT is not met as evidenced by:

Surveyor: 20031
Based on observation, interview, document review, and policy review, the provider failed to ensure staff were familiar with the provider's fire drill procedures: rescue, alarm, contain, and evacuate. Findings include:

**K 712  Corrective Action:**

6/20/2019
Therapy Director verbally educated physical therapist responding to fire drill on 5/21/2019 to ensure understanding of the facility's fire drill procedure to include the importance that fire drills are part of an established routine.

**Identification of Others:**

Administrator or designee will ensure all new or re-hired staff are educated at orientation of facility's fire drill policy and procedure and will include the importance of fire drills being part of the established routine of the procedure.
K 712 Continued From page 1

1. Observation on 5/21/19 at 11:05 a.m. of a physical therapist (PT) responding to the simulated fire in the transitional care unit's (TCU) therapy room revealed:

* A sign stating "This is a fire drill" was shown to the PT.  
* She stated "Are you kidding me? Is this for real?" in what appeared to be a negative tone of voice.  
* The PT assistant who was also in the room began to respond to the drill.  
* The PT assistant told the PT to pull the alarm and announce the fire location.  
* The PT assistant then started to close corridor doors and tell other staff of the fire drill.  
* The PT was then cued by the maintenance manager on the first step to take in a fire drill.  
* The PT was then stopped in the room by another staff person who had a question regarding a resident.

- They talked for a few seconds.  
- The PT did not tell the other staff there was a fire in the therapy room nor that she was in the middle of a fire drill.  
- The PT then proceeded to help in closing corridor doors.  
- She did not pull the alarm.  
- She did not announce the fire location.  
* The PT assistant asked the PT if she had pulled the alarm or announced the location.  
* The PT stated she was not aware she was to do those things.  
* The PT assistant then ran and pulled the alarm, and the fire location was announced overhead by a nurse in the TCU.  
* Other staff began to arrive at the simulated fire location and assist in the drill.

K 712 Administrator or designee will conduct additional fire drills during the month if a failed fire drill has occurred.

Systemic Changes:

Administrator or designee will provide education and documentation immediately after a failed fire drill to participating staff on the areas requiring improvement.

Administrator or designee will provide education to staff on the Fire Drill policy and procedure and will include roles and responsibilities regarding fire drills as established routine and the importance of staff participation in fire drills.

This education will be provided no later than 6/20/2019. Those who have not received education prior to 6/20/2019 will be educated prior to their next shift worked.

Monitoring/QAPI:

Administrator or designee will monitor monthly to validate new and current staff are competent and understand the procedure for fire drills and ensure
**K 712**  
Continued From page 2  
Interview with the maintenance supervisor at the time of the observation confirmed those findings. He revealed:  
*"It was "Not our best drill", and "They were very slow to react."*  
*The PT had worked at the facility a couple years ago. She left and then returned about one month ago.*  
*She had gone through the orientation training again that had included fire drill training.*  

2. Review of fire drill records for the past twelve months (March 2018 through March 2019) revealed six of those twelve fire drills (March, June, July, August, September, and November 2018) had a check mark in the "No" area regarding if the drill was satisfactory.  

Comments on the fire drill forms included:  
*"Staff not familiar with steps of fire drill."*  
*"No one took charge at nurse station nor did anyone follow the cheat sheet."*  
*"Walked away from fire."*  
*"Did not have a clue what to do."*  
*"Not aware of steps in fire drill."*  

Interview on 5/21/19 at 3:00 p.m. with the administrator and maintenance manager revealed:  
*"The maintenance manager had purposely ran those drill last fall with new employees.*  
*He did so to check their reactions to a fire drill.*  
*He was aware those drills were failed drills. But he had gone over the appropriate steps with the employee who had failed the drill.*  
*The administrator and the maintenance manager revealed they had considered running extra drills those months to retrain the staff. But they had not done any extra drills.*
### K 712

Continued From page 3

"The maintenance manager stated he reported at the monthly safety committee a fire drill had been completed. But he did not give any details if the drill was satisfactory or had failed.

3. Review of the provider’s undated Emergency Response Fire Drill policy revealed:

- Rolling Hills Healthcare employees are trained to utilize the R.A.C.E. Procedure.
- Rescue. Rescue/Evacuate person in immediate danger.
- Alarm. Pull nearest ‘pull station.’ Announces ‘CODE RED’ and fire location over loud speaker. Repeat the announcement.
- Confine. Confine the fire.
- Extinguish. Attempt to extinguish the fire only if the first three parts of the R.A.C.E. Procedure have been completed and the fire appears to be manageable."

The deficiency had the potential to affect 100% of the occupants of the building.
<table>
<thead>
<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<tr>
<td>S 000</td>
<td>Compliance/Noncompliance Statement</td>
<td></td>
</tr>
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<td>Surveyor: 29162</td>
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<tr>
<td></td>
<td>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/20/19 through 5/23/19. Rolling Hills Healthcare was found in compliance.</td>
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<td>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 5/20/19 through 5/23/19. Rolling Hills Healthcare was found in compliance.</td>
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