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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435035 | A. BUILDING _____ B. WING _____ | 09/27/2023 |

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

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| F 000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/25/23 through 9/27/23. Rolling Hills Healthcare was found not in compliance with the following requirements: F558, F561, F584, F684, F761, F812, and F880. | F 000 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to ensure:<br>*One of twenty-four sampled residents (30) had their wheelchair maintained in a safe condition and had a call call light placed within their reach and their functional ability.<br>*One of twenty-four sampled residents (27) had clothing that was accessible and visible to allow for independent choices with dressing.<br>Findings include:<br><br>1. Observation and interview on 9/25/23 at 11:23 a.m. with resident 30 while he was sitting in the 300-wing resident's common area revealed:<br>*He was sitting in a specialized wheelchair in the middle of the large commons area facing a television.<br>*He was alert and communicated appropriately to questions by saying "yes" and "no", moving his | F 558 | Corrective Action<br>Resident 30's wheelchair was repaired by 10/13/2023 with all exposed safety concerns addressed. Protection was added to bilateral foot pedals around calf area on 9/27/2023. Family replaced arm rest on 10/12/2023. Right arm rest circle protector added 10/12/2023. Bilateral heel loop bolt on foot pedals removed 10/13/2023.<br><br>Resident 30 was provided a soft touch call light during survey and provided a more appropriate squeeze ball call light on 9/29/2023.<br><br>Resident 27's clothing was lowered on 10/12/2023 to be more accessible in her closet with a light expected delivery before 10/31/2023 to allow independent choices with dressing. Resident 27's closet door was repaired on 10/9/2023.<br><br>DON completed a skin assessment on resident 30 on 10/16/2023 with no noted scratches or reddened areas after completed wheelchair maintenance. | 10/31/2023 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: T Harwood
TITLE: Licensed Nursing Home Administrator
(X6) DATE: 10/20/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 558 | Continued From page 1<br>head in a similar manner, and by using facial expressions and hand gestures.<br>*He had spastic but purposeful gross motor movement of his upper and lower limbs.<br>*He had been wearing shorts and had three horizontal lines of thin, scabbed, skin abrasions that were located on the middle lateral side of his left calf.<br>-He indicated he was not aware of how he had received those scratches.<br>*His wheelchair had:<br>-Unpadded round metal armrest poles that extended about four inches beyond the front of each padded armrest.<br>-Multiple small cracks were located in the vinyl fabric that had covered each armrest padding.<br>-Exposed screw heads around an adjuster ring on each leg of the wheelchair that were used to adjust the wheelchair's foot pedal length.<br>--Those screws had a rough surface that corresponded to the same height as the resident's abrasions on his left calf.<br>-One large, exposed metal screw was screwed through the back surface of each foot pedal that extended upwards about three inches.<br>--Those screws would have prevented his feet from sliding off the backside of each foot pedal.<br><br>Review of resident 30's medical record revealed:<br>*He had been admitted from his family home approximately eight months ago.<br>*Approximately ten years ago he had sustained a traumatic brain injury.<br>*His June 2023 Minimum Data Set (MDS) reflected:<br>-He had a BIMS (Brief Interview of Mental Status) score of six, indicating he had severe cognitive impairment.<br>-He required extensive assistance from two | F 558 | Identification of others<br>All residents who reside in the facility are at risk for wheelchair safety, call light accessibility and room modifications to allow independent choices with dressing, and check for any maintenance needs.<br><br>Resident assigned Advocates will check with all residents and interview those able for desired room modifications needs by 10/31/2023.<br><br>Resident Advocates will check to ensure all residents have a call light accessible that they are able to use on or before 10/20/2023.<br><br>Resident assigned advocates will review all resident wheelchairs on or before 10/31/2023 for exposed screws, vinyl tears, and sharp areas that could cause skin injury.<br><br>Maintenance will complete a full walk through of each room to addressing windows, painting, and other maintenance needs by 10/31/2023.<br><br>Systemic Changes<br>Therapy or nursing will assess needs of specialty call lights on new admissions, change of conditions or decline.<br><br>Maintenance will increase room walk throughs from yearly to quarterly to identify repair needs. | |

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| F 558 | Continued From page 2<br>persons in all areas of his daily living and functional status.<br>*His diagnoses included:<br>-Fracture of vault of the skull.<br>-Other signs and symptoms involving cognitive functions and awareness.<br>-Lack of coordination.<br>-Cramp and spasm.<br>-Contracture of muscle, unspecified site.<br>-Limitation of activities due to disability.<br>-Unspecified convulsions.<br>-Other seizures.<br>-Neurogenic bowel.<br>-Neuromuscular dysfunction of the bladder.<br><br>Interview on 9/27/23 at 11:00 a.m. with occupational therapist (OT) O regarding resident 30's wheelchair revealed:<br>*She had not been his primary therapist but knew the resident and his condition well.<br>*OT P was his therapist.<br>*If there was any wheelchair issues identified, they have a separate company [name] would come to evaluate the wheelchair.<br>*The resident was admitted from home with his current wheelchair.<br>*She stated, "Depending on payment sources, it could be a lengthy time and paperwork process to obtain a new wheelchair."<br><br>Observation and interview on 9/27/23 at 11:10 a.m. with OT P with resident 30 while he sat in his wheelchair revealed:<br>*She had been his OT for approximately three months.<br>*He was seen for OT three times a week.<br>-They worked on his motor movement and strengthening.<br>*She had not been aware of the wheelchair | F 558 | Maintenance will review resident wheelchairs quarterly to identify safety concerns and maintenance needs.<br><br>Resident advocates will observe wheelchairs weekly for obvious safety or maintenance concerns that include exposed nails, tears in vinyl/padding.<br><br>LNHA, Interdisciplinary Team (IDT) and Medical Director reviewed and approved Maintenance Policy and Work Orders Policy.<br><br>LNHA or designee will educate all staff on maintenance TELS program to report maintenance needs including wheelchair safety, closet doors, and resident requests for room modifications.<br><br>LNHA will educate Maintenance Director on TELS program, Maintenance Policy and Work Orders Policy.<br><br>Education will be completed by 10/31/2023.LNHA will ensure, through staff listing, of completed education with staff signature. Those who have not received education by 10/31/2023 will be reported to department manager they require to be educated prior to next working shift. | |

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| F 558 | Continued From page 3<br>issues that were identified above.<br>*The resident had been sitting with his right foot crossed over onto his left thigh and his right thigh resting on the right exposed metal armrest pole.<br>-When requested, he uncrossed his leg, and two visible indentations were left on his right thigh from the metal armrest pole.<br>-She observed the indentations on his skin and stated, "That's not good."<br>*She agreed the scratches on his left calf were at the same height as the screws on the foot pedal adjustment ring.<br>*She agreed the metal screws on the foot pedals could have potentially injured his heels if he had not been wearing shoes.<br>*She had padding she could have temporarily used to cover those areas of concern.<br>*She had not contacted [name of company] to evaluate his wheelchair.<br>-She agreed the wheelchair's armrests, leg extenders, and foot pedals needed evaluation for safety.<br><br>Further observation and interview on 9/27/23 at 10:00 a.m. with resident 30 while sitting in his room revealed:<br>*He was sitting in his specialized wheelchair in the middle of his room facing his television.<br>*On the opposite wall behind him, there was a push button call light with the push button activator attached to the cord hanging from the wall.<br>-He had been unable to reach the call light, and verified by shaking his head "No" that he was able to grasp the cord and push the button if he could reach it.<br>-He had raised his arms and his eyebrows in an 'I do not know' gesture when asked how he had been able to ring for assistance. | F 558 | Monitoring<br>Maintenance Director or designee will observe wheelchairs quarterly with a full inspection of wheelchair for safety and maintenance needs. LNHA or designee will monitor through documentation review, monthly x 3 months to ensure all resident wheelchairs are included in quarterly inspections.<br><br>Director of Nursing (DON) or designee will monitor resident call light placement through observation and interviews to ensure call light is within reach and appropriate while the resident is in their room and per the resident's functional ability.<br><br>LNHA or designee will monitor resident rooms through observation and interview to ensure residents rooms are modified per their choice.<br><br>All monitoring will be completed through interview, chart review or observation and documented on audit forms 2 days a week with random number of 2-5 sampled residents a week and rotated to various shifts unless otherwise specified. Audits will increase or decrease days or number of residents based upon findings of audits, as determined by LNHA and IDT, and until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 2 months. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed. | |

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| F 558 | Continued From page 4<br>*Stated "No" when asked if he had ever been able to ring for assistance and stated "Yes" when asked if he would have liked to have had that ability.<br><br>Interview on 9/27/23 at 10:10 a.m. with administrator A and director of nursing (DON) B, and with resident 30 in his room, regarding his call light preferences revealed:<br>*He had been asked and given permission for the surveyor to review his preferences, and speak on his behalf, with the administrative staff while he was present.<br>*Administrator A and DON B confirmed his call light had not been within his reach.<br>*Administrator A stated, "He is usually out in the main area watching television."<br>*They had not responded when posed with the question of how he would have been able to make his needs known, given his physical limitations, when he was in his room.<br>*Administrator A stated the resident would need an evaluation by therapy about training on the use of a pressure pad type of call light adaptation.<br>-The resident then demonstrated, by hitting his chest with the palm of his hand, the ability to activate a pressure pad call light if it were attached to his chest.<br><br>Review of resident 30's 9/27/23 revised care plan revealed:<br>*The care plan was revised on the date of the surveyor's request for a copy of the care plan.<br>*"Focus. Self care deficit r/t (related to) cognitive impairment, impaired mobility and transfer ability."<br>-"Goal. Resident will participate as able in ADL's (activities of daily living) and have all basic self care needs met at all times through next 90 day review." | F 558 | | |

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| F 558 | Continued From page 5<br>-"Interventions: Assess need for adaptive equipment and provide PRN [as needed]."<br>--"Keep needed objects within easy reach allow adequate time for accomplishment of self-care activities perform actions to increase physical mobility."<br>*"Focus. Risk for Impaired Communication r/t unclear speech, sometimes understood."<br>-"Goal: Resident will demonstrate understanding of communication by feedback daily through next 90 day review."<br>-"Check for feedback to assure comprehension."<br>-"Use short simple words and sentences."<br><br>Interview on 9/27/23 at 5:00 p.m. with administrator A, DON B, and corporate registered nurse (RN) K regarding resident 30's call light availability revealed:<br>*Administrator A stated:<br>-"In my opinion, he does not understand how to use it [call light] as he has been ringing it continually [since a pressure pad call light was provided today]."<br>-"We anticipate his needs."<br>-"He is checked on every two hours when he is in his room."<br>-"I do not feel he should have an available call light as he doesn't know how to use it and cannot verbalize."<br><br>A wheelchair maintenance policy had been requested on 9/26/23. Administrator A stated wheelchair maintenance was addressed on the work order maintenance policy. Review of the undated work order maintenance policy revealed there was no mentioned of any repair or maintenance of the resident's wheelchairs.<br><br>Review of the provider's 2018 'ADLs, Supporting' | F 558 | | |

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| F 558 | Continued From page 6<br>policy revealed:<br>*"2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:"<br>-"e. Communication (speech, language, and any functional communication systems)."<br>*"6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice."<br>*"7. The resident's response to interventions will be monitored, evaluated and revised as appropriate."<br><br>2. Observation and interview on 9/25/23 at 4:32 p.m. with resident 27 while in her room revealed:<br>*She had been a resident there for over three years.<br>*She stated she had macular degeneration and had difficulty with her vision, especially in dark environments.<br>*She stated she could rise to stand from her wheelchair, but felt unsteady on her feet.<br>-She had been unable to walk by herself and had fallen in the past.<br>*She liked to pick out her clothing and dress herself as much as possible, and staff had been encouraging her to dress herself.<br>*She had difficulty opening her closet door, as it had needed repair, and only opened if she pulled the door out from the bottom before it would slide open.<br>*She had been unable to see her clothing as her closet was dark.<br>*Her clothing had been hanging on a clothing rod | F 558 | | |

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| F 558 | Continued From page 7<br>with a height of about six feet.<br>-She stated the only way she could reach her clothing was to stand up from her wheelchair and reach up above her head to grasp the bottom of the hangers.<br>-She had broken many plastic hangers trying to get her clothing unhooked from the rod.<br>*She had asked staff many times and maintenance several weeks ago to install a light and to lower the clothes rod so she could reach her clothes.<br>-She was unable to recall the names of the staff she had asked.<br>-"But nothing has changed."<br><br>Review of resident 27's record revealed she had a BIMS score of fourteen, indicating she was cognitively intact.<br><br>Interview on 9/27/23 at 2:59 p.m. with maintenance director L regarding resident 27's closet revealed:<br>*He was not aware:<br>-The closet door needed to be pulled out before it would slide.<br>-Because of her diminished vision, the closet was too dark for her to see the contents.<br>-The height of the clothing rod was placed too high for her to retrieve her clothing independently and safely.<br>*He stated, "Staff should have been filling out work orders about this."<br>-He stated, "Sometimes we get work orders."<br>-He was sure administrator A covered completion of work orders during the annual staff training.<br>*He tried to complete a yearly facility walk-through of all the rooms, to inspect for maintenance needs, as a part of pre-survey preparedness. | F 558 | | |

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| F 558 | Continued From page 8<br>-His last walk-through was completed prior to the last survey conducted in September of 2022.<br>*Agreed a more frequent walk-through would have helped identify any resident room maintenance issues.<br><br>Interview on 9/27/23 at 5:00 p.m. with administrator A, DON B, and corporate RN K regarding resident 27's closet revealed:<br>*They were not aware:<br>-The closet door needed to be pulled out before it would slide.<br>-Because of her diminished vision, the closet was too dark for her to see the contents.<br>-The height of the clothing rod was placed too high for her to retrieve her clothing independently and safely.<br>*Administrator A stated work order requests were a part of staff orientation and all staff knew where the maintenance requests were located.<br>-New staff could have gone to the shift assigned 'mentor (Staff member with facility experience)' and ask where the maintenance requests were located.<br><br>Review of the providers undated 'Work Orders, Maintenance' policy revealed:<br>*"Maintenance work orders shall be completed in order to establish a priority of maintenance service."<br>-"1. In order to establish a priority of maintenance service, work orders must be filled out and forwarded to the Maintenance Director."<br>-"2. It shall be the responsibility of the department directors to fill out and forward such work orders to the Maintenance Director."<br>-"3. A supply of work orders is maintained at each nurses' station."<br>-"4. Work order requests should be placed in the | F 558 | | |

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| F 558 | Continued From page 9<br>appropriate file basket at the nurses' station. Work orders are picked up daily."<br>-"5. Emergency requests will be given priority in making necessary repairs." | F 558 | Corrective Action<br>Residents 6, 22, 30 were interviewed on 10/16/2023 of desired bathing preferences and bathing schedule updated with preferences. | 10/31/2023 |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, | F 561 | Residents 30 and 22 were bathed on 9/27/2023. Resident 6 was bathed on 9/28/2023.<br><br>Identification of Others<br>All residents who reside in the facility are at risk of not receiving bathing according to their preferences.<br><br>Resident assigned Advocates will meet with all current residents who are able to identify their preferences by 10/31/2023, to determine their desired bathing preferences and report to DON.<br><br>Systemic Changes<br>DON will update bathing schedule with resident requests and new admissions to reflect resident preferences on 10/20/2023<br><br>Resident advocates will discuss at least monthly with residents on bathing to ensure preferences are being met. Documentation will be provided on advocate rounds and given to LNHA at least monthly.<br><br>LNHA, IDT, DON and Medical Director created and approved a Bathing Resident's Policy. Policy is provided to all current residents and will be provided to all new residents on or before 10/20/2023. | |

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| F 561 | Continued From page 10<br>and policy review, the provider failed to ensure three of twenty-four sampled residents (6, 22, and 30) had received a bath or shower according to their desired frequency preferences. Findings include:<br><br>1. Observation and interview on 9/27/23 at 8:30 a.m. with resident 6 revealed he:<br>*He had greasy, uncombed hair and a body odor of urine.<br>*Stated, "I am supposed to get a shower once a week. Sometimes it is only once every two weeks."<br>*Had never refused a shower and would have been happy if he could have received at least one shower a week.<br>-Thought the reason that had not happened was because there was not a full-time bath person employed by the facility.<br><br>Review of resident 6's record revealed he:<br>*Had a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact.<br>*Had been a resident since 2014.<br><br>2. Observation and interview on 9/25/23 at 11:19 a.m. with resident 30 revealed he:<br>*Was sitting in a specialized wheelchair in the middle of the large commons area facing a television.<br>*Was alert and communicated appropriately to questions by saying "yes" and "no", moving his head in a similar manner, and by using facial expressions and hand gestures.<br>*Had spastic but purposeful gross motor movement of his upper and lower limbs.<br>*Had greasy hair with a mild body odor of sweat and urine.<br>*Said "no" when asked if he was getting enough | F 561 | LNHA or designee will provide education to nursing staff on new Bathing Residents Policy by 10/31/2023.Education will be completed by 10/31/2023.<br>LNHA will ensure, through staff listing, of completed education with staff signature. Those who have not received education by 10/31/2023 will be reported to department manager they require to be educated prior to next working shift.<br><br>Monitoring<br>DON or designee will monitor new admissions through chart review and interviews to ensure bathing preference checklist is completed and bathing schedule is updated.<br><br>DON or designee will monitor residents through interview and chart review to ensure residents are being bathed per their preferences.<br><br>All monitoring will be documented on audit forms 2 days a week with random number of 2-5 sampled residents a week and rotated to various shifts unless otherwise specified. Audits will increase or decrease days or number of residents based upon findings of audits, as determined by LNHA and IDT, and until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 2 months. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed. | |

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showers.
-When asked how often he would like a shower, he said "no" to one time a week, "no" to twice a week, and "yes" to three times a week.

Review of resident 30's record revealed he:
*Had a BIMS score of 6, indicating severe cognitive impairment.
*Had a severe traumatic brain injury approximately ten years ago.
*Had been a resident since 2022.

3. Observation and interview on 9/25/23 at 3:29 p.m. with resident 22 revealed he:
*Was sitting in his wheelchair wearing a shirt and shorts.
*Had slightly greasy hair.
*Stated he had been getting baths two times a week when he first had come to the facility in 2017.
-Over the last year he had been getting only one bath a week.
-Would have preferred a bath two times a week.

Record Review on 9/25/23 at 3:50 p.m. of resident 22 revealed he:
*Had a Brief Interview for Mental Status (BIMS) of 15 indicating he was cognitively intact.
*Had been at the facility since 2017.
*Diagnosis includes: cerebral infarction, morbid (severe) obesity, essential (primary) hypertension, and hemiplegia.
*Had received only three baths in the last 30 days, 9/5/23, 9/20/23 and 9/27/23
-Indicating he had gone 15 days without receiving a bath.

Interview on 9/27/23 at 7:59 a.m. with qualified

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| F 561 | Continued From page 12 | F 561 | | |

activities director D revealed she:
*Had been employed at the facility for 33 years.
-Had been the activities director since prior to COVID pandemic.
*Had been giving baths one to two times a week.
-Stated she had been helping as a bath aide as they do not have a full-time bath aide available.
-Stated there was an open full-time bath aide position.
*Stated every resident was scheduled for a bath one time a week.
*Knew resident 22 would have preferred a bath two times a week.
-Stated they used to give baths two times a week but not sure why they do not provide that anymore.

Interview on 9/27/23 at 3:45 p.m. with staff scheduler E revealed she:
*Had been asking residents on admission their frequency preference for bathing.
-Stated the residents were asked at care conferences about their frequency preference for bathing.
*Stated staffing is the issue for meeting a resident's preference.
*Stated a full-time bath aide would allow the residents to have their bathing preferences met.
-Stated, "Facility is trying to hire a full-time bath aide, but nobody wants to work."

Interview on 9/27/23 at 5:23 p.m. with administrator A revealed she:
*Stated she had called other facilities and one time a week for a resident bath was normal.
*Stated they were trying to accommodate the residents bathing frequency preference.
*Stated with one staff member filling the position of a full-time bath aide they would not be meeting

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| F 561 | Continued From page 13<br>the preferred frequency preference of the residents.<br>-Stated they were trying to get enough staff hired to have been able to have a full-time bath aide.<br><br>Requested a bathing policy on 9/26/23 and was referred to their Activities of Daily Living (ADLs) policy. There was no mention of a bathing preference in the ADLs policy.<br><br>Refer to F684 findings 1 and 2. | F 561 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are | F 584 | Corrections<br>Resident 30's family was contacted during survey and has provided decorations for resident's room to accommodate a homelike environment. The clock was moved to allow resident 30 to view while in bed and a calendar was placed in resident's room on 10/16/23. Resident 30 reported satisfied with room décor on 10/16/2023.<br><br>Social Services Director (SSD) called resident's prior ALF on 9/27/23 and verified all belongings have been delivered to resident from ALF. SSD discussed with residents of additional belongings on 10/16/2023 and updated on what family had removed from ALF. Resident 23 reported satisfied with current room décor and clock placement on 10/16/2023. All unused recliners were removed from 300-day area during survey. All recliners in 300-day area were cleaned by 10/13/2023. Washable | 10/31/2023 |

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| F 584 | Continued From page 14<br>in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the facility failed to ensure:<br>*Two of twenty-four sampled resident's (23 and 30) rooms had been maintained in a homelike environment.<br>*One of one carpeted resident daytime use area (300 wing) had carpet that was free from stains and odors.<br>*Four of twenty-four facility recliners located throughout two of two resident daytime use areas (300 wing and the Day room) had been free from stains or odors.<br>*Three of three resident wing hallways (200, 300, and 400) had resident room doorways that were free from missing paint.<br>*Two of two residents (30 and 46) specialized wheelchairs were kept in a well maintained condition.<br>*One of one resident rooms (213) had a window free from broken glass and a warped windowsill with exposed nails.<br>Findings include: | F 584 | recliner covers were ordered and applied to all resident use recliners in the 300-day area on 10/5/2023. Any recliners not cleanable were removed before 10/13/2023.<br><br>Facility has requested quote from Hills Interior on 10/12/2023 to remove carpet in 300-day area and replace with non-carpeted flooring. Room 213 window was removed and taken to local glass repair during survey. Exposed nails were remedied during survey.<br><br>Doorways on 200, 300 and 400 with missing paint have all been painted on or before 10/20/2023.<br><br>Resident 46 has expired, and wheelchair has been removed and taken to maintenance for cleaning on 10/16/2023.<br><br>Resident 30's wheelchair was inspected and cleaned on 10/13/2023.<br><br>Identification of Others<br>All residents residing in facility are at risk for not having a homelike environment room. Resident advocates will interview all residents on or before 10/31/2023 on preferred room decorations and requests, check if residents can see calendar or if they would like one. | |

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| F 584 | Continued From page 15<br><br>1. Observation and interview on 9/25/23 at 11:19 a.m. with resident 30 regarding his room revealed:<br>*He was sitting in a specialized wheelchair in the middle of his room facing a television.<br>*He was alert and communicated appropriately to questions by saying "yes" and "no", moving his head in a similar manner, and by using facial expressions and hand gestures.<br>*He had spastic but purposeful gross motor movement of his upper and lower limbs.<br>*His walls were bare except for:<br>-A 4 x 6 picture of a popular musician thumb-tacked on the wall next to his wall-mounted television.<br>-A corkboard that contained a reminder to ring for assistance.<br>-A small wall clock hanging next to his closet that was not within his view from the bed.<br>-There was no calendar located in his room.<br>*He indicated by nodding his head and saying "yes" that he would have liked something to look at on his walls.<br><br>Review of resident 30's record revealed he:<br>*Had a BIMS score of 6, indicating severe cognitive impairment.<br>*Had a severe traumatic brain injury approximately ten years ago.<br>*Had been a resident since 2022.<br><br>2. Observation and interview on 9/26/23 at 9:26 a.m. with resident 23 while in his room revealed:<br>*He stated, "I have lived here for 100 days, and I still don't have my belongings from [name of prior assisted living facility]."<br>-"I asked here, and they told me they can't help me." | F 584 | All findings will be accommodated or scheduled with maintenance to correct. Families or residents will be notified of all request's facility is unable to accommodate.<br><br>Maintenance will complete a full walk through of each room to address windows and painting needs on or before 10/31/2023.<br><br>Systemic Changes<br>Housekeeping has created a cleaning log to provide regular cleaning of recliners and carpets and recliner covers.<br><br>Maintenance will increase room walk throughs from yearly to quarterly to identify painting, other maintenance, and wheelchair maintenance needs.<br><br>Resident advocates will inspect wheelchairs weekly for cleaning needs, provide minor cleaning as needed, or request for maintenance to complete a pressure clean on wheelchair. Documentation will be provided on advocate rounds form and given to LNHA.<br>Nurse aides will complete cleaning of wheelchair on scheduled bath days.<br><br>LNHA, IDT, and Medical Director reviewed and approved Cleaning/Repairing Carpeting and Cloth Furnishings Policy and Cleaning and Disinfection of Resident-Care items and Equipment Policy and Maintenance Work Orders Policy. | |

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| F 584 | Continued From page 16<br>*His walls were bare except for a calendar and care reminder messages.<br>*He stated, "I'm an orphan here, all I want is just a place. I'm not happy here."<br><br>Review of resident 23's record revealed he:<br>*Had a BIMS score of 12, indicating mild cognitive impairment.<br>*Had diagnoses of depression and dementia.<br>*Had been a resident since May 2023.<br><br>Interview on 9/27/23 at 10:45 a.m. with social services director C and at 12:30 p.m. with social service assistant (SSA) U regarding resident 23 and 30's lack of room decorations revealed:<br>*Activities ask the residents their room decoration preferences.<br>*They expected the resident or family members to decorate the resident's room.<br>*Resident 30's father had stated he would decorate the room, but that had not been done.<br>*Resident 23's family had not provided any decorative items.<br>-They were unsure if there had been any of his remaining personal items left at the assisted living facility he had previously resided.<br>-They had discussed with resident 23 his miscellaneous concerns on a weekly basis.<br>-He was having difficulty adjusting to the facility.<br>*SSA U stated, "More could have done for both residents, prior to now, to accommodate their [room decoration] needs."<br><br>Interview on 9/27/23 at 4:55 p.m. with administrator A, director of nursing (DON) B, and corporate registered nurse K, regarding resident room decorations revealed:<br>*Administrator A stated:<br>-"Families are encouraged to bring in personal | F 584 | LNHA or designee will educate all staff on maintenance TELS program to report maintenance needs including window repairs and exposed nails.<br><br>LNHA will provide education to Housekeeping Manager to report to LNHA of any recliners or flooring that is not cleanable for proper repair or disposal.<br><br>Room 213 will remain vacant until window repairs are completed.<br><br>Facility will remove 300-day area carpet as soon as able. Once the quotes are received, process approval for capitalization of expense will be completed and budgeted into current expenses. Carpet will not be incorporated as a future plan.<br><br>Education will be completed by 10/31/2023. LNHA will ensure, through staff listing, of completed education with staff signature. Those who have not received education by 10/31/2023 will be reported to department manager they require to be educated prior to next working shift.<br><br>Monitoring<br>LNHA or designee will monitor through observation and documentation of regular cleaning of recliners. | |

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| F 584 | Continued From page 17<br>items."<br>-"Not really anything we have to decorate [with] other than craft items."<br>-"Unless a resident complains, we don't just put stuff on the walls for them."<br>-"Resident [name] 30's father says he is bringing it [decorations] in but has not."<br>-"It is not something we ask [family's] as part of our quarterly process."<br><br>Review of the provider's 2006 Activities policy had no mention regarding residents room preferences or decorations.<br><br>3. Observation on 9/25/23 at 11:15 a.m. of the 300-wing daytime use area revealed:<br>*A large, carpeted, resident multi-use room that held multiple recliners in a semi-circle around a large television, a piano, several independent sitting areas, and another sitting area near a large bowed window.<br>*The multi-colored carpet had scattered brown ring-type stains throughout the semi-circle sitting area.<br>*The entire sitting area had a strong odor of urine.<br>*One recliner chair in that sitting area had a blue waterproof pad under the chair that had brown stains on it.<br>-The carpet in front of the pad had dark brown stains.<br><br>Observation on 9/25/23 at 11:10 a.m. of the 300 wing day-time use area revealed:<br>*There was a strong odor of urine throughout the area.<br>*There were twenty-one recliners located in a semi-circle facing a television and a piano.<br>-All the recliners, except for two, had breathable, absorbent, fabric upholstery. | F 584 | LNHA or designee will monitor maintenance documentation and observations to ensure regular resident room walk through and repairs and maintenance are identified and maintained.<br><br>LNHA or designee will monitor wheelchairs through observation and documentation to ensure wheelchairs are maintained and are clean, safe, and comfortable.<br><br>All monitoring will be completed through interview, chart review or observation and documented on audit forms 2 days a week with random number of 2-5 sampled residents a week and rotated to various shifts unless otherwise specified. Audits will increase or decrease days or number of residents based upon findings of audits, as determined by LNHA and IDT, and until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 2 months. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed. | |

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| F 584 | Continued From page 18<br>-They were available for any resident or visitors to sit on.<br>*One white upholstered recliner located next to the piano had a visible gray outline of a person's body.<br>*One light green recliner's seat cushion had a dried circle outline that had a strong odor of urine.<br><br>Interview on 9/27/23 at 8:15 a.m. with housekeeping staff T revealed:<br>*She had been employed as a housekeeper for about 7 months.<br>*Housekeeping was responsible for keeping the carpets and recliners clean.<br>-The carpet was shampooed about once a month.<br>-The recliners were only cleaned as needed.<br>*She was unsure if there was a carpet or recliner cleaning log.<br>*She agreed the carpet appeared stained in multiple areas.<br>*She stated the waterproof pad under the recliner mentioned above had been laundered once a week.<br>-There was a resident who liked to dump out his coffee on the carpet in front of the recliner.<br>*She had not deep cleaned the carpet or the recliners.<br>-Housekeeping director F had performed those tasks.<br><br>Interview on 9/27/23 at 2:50 p.m. with housekeeping director F regarding the carpet and recliner cleaning revealed:<br>*He had been employed for over four years.<br>*He had received complaints from visitors about the condition of the carpet.<br>*He stated, "The carpet is my biggest enemy, it was installed in 2000. I have shampooed it three | F 584 | | |

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| F 584 | Continued From page 19<br>times since mid-March and it will look good for a day or two and then the stains return. Corporate is aware of the issue."<br>*He stated the recliners had been shampooed as needed when they had become stained.<br>-He had deep-cleaned the white recliner many times and had been unable to remove the stains.<br>-He inspected the recliners every morning when he vacuumed the carpet.<br>*He stated there had been an attachment on the carpet shampooer that could also shampoo the recliners.<br>*He had not kept a log of when the carpets were shampooed or when the recliners were deep cleaned.<br>*Administrator A arrived at the interview and stated she had ordered waterproof recliner covers but they had not arrived yet.<br>-Upon the surveyor request, she provided copies of screenshots from her cell phone showing [name of shipping company] orders that had been requested after the current survey had started.<br>-She had not supplied an actual invoice and none of the screenshot pictures had indicated any covers had been shipped.<br><br>Review of the provider's undated 'Cleaning/Repairing Carpeting and Cloth Furnishings' policy stated:<br>*"All carpeting and cloth furnishings shall be cleaned regularly and repaired promptly."<br>*Carpeting and upholstered furniture was expected to have been kept in good repair and deep cleaned as needed or when visibly soiled.<br>*There was no mention of a deep-cleaning schedule or log for housekeeping staff to follow.<br><br>4. Observation on 9/25/23 at 11:00 a.m. during initial facility tour revealed: | F 584 | | |

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| F 584 | Continued From page 20<br>*Wings 200, 300, and 400, resident room doorways had paint chips missing on the lower portions of the doorways.<br>-Nearly every doorway was affected.<br>-Room 204's interior bathroom doorway had paint missing from two feet above the floor extending upwards for about twelve inches.<br><br>5. Observation on 9/25/23 at 11:23 a.m. of resident 30's specialized wheelchair revealed:<br>*Dried food particles had been encrusted into the sides and bottom of his chair.<br>-There were whole pieces of dried food laying on the flat-based bottom of his chair.<br><br>6. Observation on 9/26/23 at 4:22 p.m. of resident 46's specialized wheelchair revealed the armrests, sides, and padded seat of her chair had dried encrusted food particles.<br><br>A policy on wheelchair cleaning was requested from administrator A on 9/26/23 at 9:00 a.m., she indicated it was in the 'Cleaning and Disinfection of Resident-Care Items and Equipment' policy.<br><br>Review of the provider's 2014 'Cleaning and Disinfection of Resident-Care Items and Equipment' policy revealed:<br>*"Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC [Center for Disease Control] recommendations for disinfection and the OSHA [Occupational Safety and Health Administration] Bloodborne Pathogens Standard."<br>*There was no mention in the provider's policy on wheelchair cleaning.<br>7. Observation on 9/25/23 at 11:52 a.m. of the resident's Day Room revealed: | F 584 | | |

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| F 584 | Continued From page 21<br>*There were two unidentified residents sitting at a large round wooden table, and three recliners arranged throughout the room for residents to sit in.<br>*One of the three recliners had multiple unidentified dark brown and gray spots on the head rest, the armrest and the leg rest of the chair.<br>*One of the three recliners had a worn-down discolored spot on the head rest.<br><br>8. Observation on 9/27/23 at 2:12 p.m. of room 213 revealed:<br>*The bottom right-sided windowsill was bending in an upside U shape which revealed two nails sticking out of the bottom of the windowsill.<br>*The left-sided window had a 3-inch hole with a crack that extended the entire width and most of the length of the window.<br><br>Interview on 9/27/23 at 2:59 p.m. with maintenance director L revealed he:<br>*Had been having his staff paint the resident's doorways every six months.<br>-Stated it had been six months since the last time the resident's doorways were painted and it was time to re-paint them.<br>*Had not been aware of the cracked window or the windowsill in room 213.<br>-Stated that the staff were to fill out work orders on issues like those mentioned above.<br>-Stated he had been doing a thorough walk through once a year.<br>-Stated it had been a year since his last thorough walk through.<br>*Stated more walk through's during the year would help find issues like the ones that were mentioned above. | F 584 | | |

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| F 584 | Continued From page 22<br>Interview on 9/27/23 at 4:20 p.m. with administrator A revealed she:<br>*Stated staff were trained at orientation on how to fill out the work orders.<br>-Stated the company had been using a mentor program on each shift for the staff to go to with any questions or concerns.<br>*Stated she had seen the maintenance director L do touch-ups on the resident's doorways.<br>*Thought the cracked window had happened from the recent hailstorm. | F 584 | | |
| F 684 SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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 practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to ensure:<br>*Six of twenty-four sampled residents (8, 22, 23, 24, 27, and 31) had their call lights answered in a timely manner.<br>*Three of twenty-four sampled residents (6, 29, and 30) had received baths as they preferred or on at least a weekly basis.<br>*Three of twenty-four sampled residents (20, 33, and 202) had received nail care to maintain nail hygiene.<br>Findings include: | F 684 | Corrective Action<br>Residents 8, 22, 23, 24, 27 were interviewed by IDT members regarding call light times and grievances were made per interview and resident request on 10/16/2023. Resident 31 has discharged from facility.<br><br>Resident 8's call light was checked on 10/16/2023 to ensure it is still working.<br><br>Residents 6, 22, 30 were interviewed on 10/16/2023 of desired bathing preferences and bathing schedule updated with preferences.<br><br>Residents 20, 33, 202 were provided nail care by DON on 10/12/2023.<br><br>Resident 30 was given a bath on 9/27/2023. Resident 6 was bathed on 9/28/2023. Resident 29 was bathed on 9/27/2023. | 10/31/2023 |

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| F 684 | Continued From page 23<br>1. Observation and interview on 9/25/23 at 10:03 a.m. with resident 31 revealed she:<br>*Was sitting in her recliner with a blanket over her her legs.<br>*Stated she did not sleep the previous night due to pain in her foot.<br>.*Stated she had been having to wait close to an hour for staff to answer her call light.<br>-Stated those times had been happening between mealtimes and at night.<br><br>Record review of resident 31 revealed she:<br>*Had a Brief Interview for Mental Status (BIMS) of 15 indicating cogitative intact.<br>*Had been at the facility since 8/20/23<br>*Diagnosis includes: acute and chronic respiratory failure with hypoxia, chronic pulmonary edema, pulmonary fibrosis, and pneumonia.<br><br>2. Observation and interview on 9/25/23 at 3:29 p.m. with resident 22 revealed he:<br>*Was sitting in his wheelchair wearing a shirt and shorts.<br>*Stated he needs assistance from the certified nursing assistants to use the bathroom.<br>*Had been having to wait close to one and a half hours for his call light to have been answered by staff.<br>-Stated those times had been happening mid-morning.<br><br>Record review of resident 22 revealed he:<br>*Had a BIMS of 15 indicating cogitative intact.<br>*Had been a resident since 2017.<br>*Diagnosis includes: cerebral infarction, morbid (severe) obesity, essential (primary) hypertension, and hemiplegia.<br>*Had received only three baths in the last 30 | F 684 | Identification of others<br>All residents who reside in the facility are at risk of not receiving bathing according to their preferences, at risk of not receiving timely call light response, at risk of not receiving nail care hygiene.<br><br>Resident assigned Advocates will meet with all current residents who are able to identify their bathing preferences by 10/31/2023, to determine their desired bathing preferences and report to DON.<br><br>Resident assigned Advocates will observe all current resident's nails and report to DON of any residents needing nail care during weekly rounds and document on resident rounds form and given to LNHA weekly. Nail care will be completed on all residents on or before 10/31/2023.<br><br>Licensed Nurse will provide diabetic nail care weekly on scheduled bath day.<br><br>DON reviewed all resident's and ensured all residents were given a bath or shower by on or before 10/31/2023.<br><br>Resident assigned Advocates will interview all residents for any call light response grievances and will assist resident to fill out a grievance or complete a grievance on the resident's behalf as requested and provide to LNHA on or before 10/31/2023. | |

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| F 684 | Continued From page 24<br>days, 9/5/23, 9/20/23 and 9/27/23<br>-Indicating he had gone 15 days without receiving a bath.<br><br>3. Observation and interview on 9/25/23 at 4:36 p.m. with resident 8 revealed she:<br>*Was sitting in her wheelchair looking at her phone.<br>*Has two prosthetic legs.<br>*Has a commode next to the bed for her to use at night.<br>*Had been having to wait close to an hour for her call light to have been answered by staff.<br>-Stated those times had been happening more at night and during the weekends.<br>-Stated she had been calling the nurse's station when it was close to an hour wait.<br>*Stated the staff told her that her call light system was broke and had given her a new call light system last week.<br><br>Record review of resident 8 revealed she:<br>*Had a BIMS of 15 indicating he is cogitatively intact.<br>*Had been a resident since 6/13/23.<br>*Diagnosis includes: orthopedic aftercare following surgical amputation, absence of right and left legs below the knee.<br><br>Interview on 9/27/23 at 4:47 p.m. with administration A and director of nursing (DON) B revealed they:<br>*Stated there was no way for them to run an audit of the residents call light wait times.<br>*Had been having the residents fill out a grievance form for long call light wait times.<br>-Discussed the call light waits time at the resident council last month.<br>*Stated they would have completed an internal | F 684 | Systemic Changes.<br>LNHA, IDT, DON and Medical Director created and approved a Bathing Resident's and ADL Policy. Bathing Policy is provided to all current residents and will be provided to all new residents.<br><br>DON updated bathing schedule to reflect resident preferences. Bathing will include nail care<br><br>DON did create a desired bathing preference interview for all new admissions. Admitting charge nurse will complete the checklist for all new admissions and report to DON to update schedule.<br><br>Resident Advocates will report to DON after visits of any nail care needs and will assist with answering call lights during rounds and report to DON call light grievances.<br><br>Facility ordered hand wipes for mealtimes for resident use to assist with hand hygiene and nail care before and after meals.<br><br>LNHA or designee will provide education to all direct care staff/nursing staff on the Bathing and ADL policy to include nail hygiene during resident cares. | |

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| F 684 | Continued From page 25<br>audit if residents were complaining of long call light wait times.<br>-Had been looking into the complaints of long call light wait times over the past month.<br>-Reviewed the time of day that the complaints and then had been educating the staff.<br><br>4. Random observations on 9/25/23 from 8:30 a.m. through 11:23 a.m. revealed:<br>*Resident 202 fingernails had unidentified dark spots under her fingernails with light tan and brown color around her fingernails.<br>*Resident 33 fingernails had unidentified dark spots under her fingernails and with brown color around her fingernails and a foul-smelling left hand with an odor of feces.<br><br>5. Observation on 9/26/23 at 10:02 a.m. of resident 20 revealed her fingernails had unidentified dark spots under her fingernails and light tan and brown color around her fingernails.<br><br>Interview on 9/27/23 at 4:53 p.m. with administrator A and DON B revealed they:<br>*Stated the certified nursing assistants (CNAs) use a washcloth to wash the residents' hands when they were soiled.<br>-Stated the CNAs would have assisted the residents clean their hands after toileting and before all meals.<br>-Stated the CNAs would have gotten the resident into the tub to clean their hands and fingernails if they could not get them clean with a washcloth.<br>*Stated the CNAs have been trained in nail care.<br>-Stated nail care was part of the Activities of Daily Living (ADLs) that the CNAs provide.<br>6. Observation and interview on 9/25/23 at 3:30 p.m. with resident 24 revealed she:<br>*Was sitting in her wheelchair in her room with an | F 684 | LNHA or designee will provide education to all direct care staff of resident expectation of call light response within 15 minutes and include focus areas of mid-morning, meals, nights, and weekends.<br><br>Education to nurses will include monitoring call lights and instructing direct care staff or assisting with timely call light responses.<br><br>Education will be completed by 10/31/2023.LNHA will ensure, through staff listing, of completed education with staff signature. Those who have not received education by 10/31/2023 will be reported to department manager they require to be educated prior to next working shift.<br><br>Monitoring<br>DON or designee will monitor residents to ensure residents are being bathed per their preferences and as scheduled.<br><br>DON or designee will monitor residents to ensure nail care is being completed during resident cares, after meals and during bathing as needed, and to ensure hand wipes are available at meals.<br><br>DON or designee will monitor resident's call light response times to ensure residents call lights are being answered as they desire. | |

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| F 684 | Continued From page 26<br>anxious look on her face.<br>*Stated she had desperately needed to use the restroom.<br>*Her call light was on and had been ringing since 3:08 p.m. according to the monitor located outside of her room.<br>-She had been waiting for twenty-two minutes.<br>*Stated her usual call light wait time was over half-an-hour and she had been frequently incontinent while waiting for assistance.<br><br>Review of resident 24's record revealed she:<br>*Had a Brief Interview of Mental Status (BIMS) score of 12, indicating she was moderately cognitively impaired.<br>*Had a 9/21/23 Minimum Data Set (MDS) indicating she required maximal staff assistance with toileting and was frequently incontinent.<br>*Had been a resident since April 2017.<br><br>7. Observation and interview on 9/25/23 at 4:32 p.m. with resident 27 revealed she:<br>*Was sitting in her wheelchair in a nicely decorated room.<br>*Was pleasant, nicely dressed, and appeared to be well maintained.<br>*Stated she suffered from urinary urgency, was frequently incontinent, and often had to wait over fifteen minutes for her call light to get answered by staff so she could be assisted to the restroom.<br>-Felt she would have had less incontinence if her call light was answered promptly.<br><br>Review of resident 27's record revealed she:<br>*Had a BIMS score of 14, indicating she was cognitively intact.<br>*Had a 7/20/23 MDS indicating she required extensive assistance from staff with toileting and was frequently incontinent. | F 684 | All monitoring will be completed through interview, chart review or observation and documented on audit forms 2 days a week with random number of 2-5 sampled residents a week and rotated to various shifts unless otherwise specified. Audits will increase or decrease days or number of residents based upon findings of audits, as determined by LNHA and IDT, and until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 2 months. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed. | |

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| F 684 | Continued From page 27<br>*Had a diagnosis of overactive bladder.<br>*Had been a resident since February 2020.<br><br>8. Observation and interview on 9/26/23 at 9:26 a.m. with resident 23 revealed he:<br>*Had an untidy appearance with a body odor of urine.<br>*Stated, "I don't have much luck ringing for help, it is not unusual that they don't come to help me."<br><br>Review of resident 23's record revealed he:<br>*Had a BIMS score of 12, indicating he was moderately cognitively impaired.<br>*Had diagnoses of depression, dementia, mild cognitive impairment, and an enlarged prostate gland.<br>*Had been a resident since May 2023.<br><br>9. Observation and interview on 9/25/23 at 11:23 a.m. with resident 30 revealed he:<br>*Was only able to communicate by saying "yes" or "no" and by facial gestures and head nods.<br>-Had been able to answer simple yes and no questions appropriately.<br>*Had greasy hair, and an odor of sweat and urine to his body.<br>*He stated "yes" to question of having had one bath a week and "no" to question if that had been enough.<br>-Stated "no" to question of wanting a twice a week bathing and "yes" to question of wanting three times a week bathing.<br><br>Review of resident 30's record revealed he:<br>*Had a BIMS score of 6, indicating he had severe cognitive impairment.<br>-Had an upcoming psychiatric evaluation to determine his cognitive abilities.<br>*Had sustained a traumatic brain injury when he | F 684 | | |

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| F 684 | Continued From page 28 | F 684 | | |

was a teenager.
*Had a 9/23/23 MDS indicating he needed extensive assistance from staff with bathing.
*Had been a resident since October 2022.
*Review of his last thirty days of bathing documentation revealed he had received a bath on 9/5/23 and on again 9/20/23.
-That was a fifteen-day time interval in between his baths.

10. Observation and interview on 9/26/23 at 8:53 a.m. with resident 29 revealed he:
*Was well dressed, clean shaven, and spoke in a quiet voice.
*Stated he would have liked to have received a shower on Wednesdays, but had sometimes received them on a Thursday.
-"I never know when I will get a shower."

Review of resident 29's record revealed he:
*Had a BIMS score of 12, indicating he was moderately cognitively impaired.
*Had diagnoses of an enlarged prostate gland, chronic kidney disease, a cognitive communication deficit, an abnormal gait, and a need for assistance with personal care.
*Had been a resident since April 2023.
*Review of his last thirty days of bathing documentation revealed he had received a bath on 9/6/23, 9/13/23, and on Thursday 9/21/23.

11. Observation and interview on 9/27/23 at 8:30 a.m. with resident 6 revealed he:
*Had greasy hair and food stains on his clothing.
*Stated, "I'm supposed to get a shower once a week. Sometimes it is only once every two weeks."

Review of resident 6's record revealed he:

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| F 684 | Continued From page 29 | F 684 | | |

*Had a BIMS score of 15, indicating he was cognitively intact.
*Had been a resident since October 2014.
*Had diagnoses of schizophrenia, anxiety, muscle weakness, basal cell carcinoma, and an enlarged prostate gland.
*Review of his last thirty days of bathing documentation revealed:
-Had not received a bath on 8/31/23 or on 9/21/23.
-Had received a bath on 9/7/23, 9/14/23, and on 9/25/23.

Interview on 9/27/23 at 8:15 a.m. with activities director D while she was working in the role of the bath aide revealed:
*She had been employed for thirty-three years.
*Her main job role was the activities director.
*She had been frequently pulled out of doing activities to give resident's baths.
-That occurred one to two days every week.
-"I just jump in and help as we are trying to get away from temporary agency staffing."
*There was no scheduled full-time bath aide.
-"Sometimes the nurse aides would give baths in the morning and work the floor in the afternoons."
*If she had been unable to give all the day's scheduled baths, she would try to make sure it had been offered the following day.
*Every resident had been scheduled to receive one bath a week.
-"We used to offer more, not sure why that changed."
*She had been aware there were some residents who would have preferred more frequent baths during the week.

Review of the provider's 2018 ADLs (Activities of Daily Living) policy revealed:

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| F 684 | Continued From page 30<br>*"Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene."<br>-"2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:<br>--a. Hygiene (bathing, dressing, grooming, and oral care)" | F 684 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the | F 761 | Corrective action<br>DON reviewed residents 7, 39, 42 insulin orders and verified with MD, reviewed MAR, and faxed current insulin orders to pharmacy on 10/16/2023.<br><br>DON reviewed resident 23 roflumilast and tamsulosin orders and updated MAR on 10/11/2023.<br><br>DON provided education to LPN M and CMA N on 10/16/2023 on comparing medication labels to MAR.<br><br>DON created and placed sticker on resident 7, 39, 42 insulin and resident 23 roflumilast and tamsulosin orders to identify a medication change and to refer to MAR until updated pharmacy labels arrive. | 10/31/2023 |

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| | 435035 | A. BUILDING _____ B. WING _____ | 09/27/2023 |

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

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| F 761 | Continued From page 31<br>quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to ensure four of eight sampled residents (7, 23, 39, and 42) had prescription medications that were accurately labeled. Findings include:<br><br>1. Observation on 9/26/23 at 7:19 a.m. of licensed practical nurse (LPN) M revealed:<br>*She had prepared and administered eight units of Novolog insulin for resident 42.<br>*The prescription label on the insulin pen had instructed seven units of that insulin was to have been administered with her meals.<br><br>Review of resident 42's September 2023 Medication Administration Record (MAR) revealed:<br>*It had indicated the start date of that physician-ordered (PO) insulin was 3/27/23.<br>*Eight units of Novolog were to have been administered with her meals.<br><br>2. Continued medication administration observation at 7:24 a.m. of LPN M revealed:<br>*She had prepared and administered 30 units of Levemir insulin for resident 39.<br>*The prescription label on the insulin pen had read 45 units of insulin were to have been administered in the morning.<br><br>Review of resident 39's September 2023 MAR revealed:<br>*It had indicated the start date of that PO was 9/22/23.<br>*Thirty units of Levemir were to have been | F 761 | Identification of others<br>All residents who receive prescription medications are at risk for medication changes resulting in medication labels to be different from current order.<br><br>DON and designated nurses and medication aides will review all prescription medications for all residents on or before 10/31/2023 to ensure all current prescription medication labels are updated for current orders.<br><br>Orders that are not updated will have a licensed nurse current order verified with MD, ensure MAR is correct, sticker placed on label to identify medication change and current order faxed to pharmacy for updated labels.<br><br>Systemic Changes<br>DON created stickers indicating a medication change to place on labels and refer to MAR until updated medication card and label sent by pharmacy.<br><br>DON purchased containers and all insulins were moved to resident individual containers marked with resident name and current order for insulin dosing.<br><br>LNHA, IDT and Medical Director reviewed and approved Administering Medications Policy and Medication Ordering and Receiving from Pharmacy Policy. | |

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| F 761 | Continued From page 32<br>injected in the morning.<br><br>3. Continued medication administration observation at 7:33 a.m. of LPN M revealed:<br>*She had prepared and administered three units of Novolog for resident 7.<br>-The prescription label on that insulin pen referred only to the use of that insulin in conjunction with a sliding scale (a physician-ordered scale that varies the dose of insulin based on a person's blood sugar reading).<br><br>Review of resident 7's September 2023 MAR revealed:<br>-It had indicated the start date of that PO was 10/9/22.<br>-Three units of Novolog were to have been injected before meals with additional units to have been given at that same time according to the sliding scale.<br><br>Interview on 9/26/23 between 7:19 a.m. and 7:33 a.m. with LPN M regarding her observed medication administrations referred to above revealed she had:<br>*Not compared the prescription label information against the MAR instructions for that same medication prior to medication administration.<br>*Thought the physician's orders for the medications referred to above "must have changed" therefore there had been a discrepancy between the label instructions and the MAR.<br>*She was expected to have placed a "change order sticker" on prescription labels when the label and the MAR order had not matched.<br>-That alerted other licensed nurses that a change in that medication had occurred.<br><br>4. Observation on 9/26/23 at 7:45 a.m. with | F 761 | DON or designee will provide education to all nurses and medication aides on the Administering Medications Policy and Medication ordering and receiving from pharmacy policy to include use of med change sticker, updating MAR, ensuring order matches the MAR, and med change process with stickers.<br><br>Education will be completed by 10/31/2023.LNHA will ensure, through staff listing, of completed education with staff signature. Those who have not received education by 10/31/2023 will be reported to department manager they require to be educated prior to next working shift.<br><br>Monitoring<br>DON or designee will monitor resident medication changes to ensure medication labels are marked with a sticker as order changes and pharmacy sends updated medication with correct label.<br><br>DON or designee will monitor staff to ensure staff are checking right resident, right medication, right dosage, right time and right method (route) while administering medications. | |

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| F 761 | Continued From page 33<br>certified medication aide (CMA) N revealed:<br>*She had prepared and administered two-250 mg (milligram) roflumilast tablets for resident 23.<br>-The prescription label on that medication had read one-250 mg (milligram) tablet was to have been taken daily.<br>*She had prepared and administered one-0.4 mg capsule of tamsulosin to that same resident<br>-The prescription label on that medication had read it was to have been taken at "dinner".<br><br>Review of resident 23's September 2023 MAR revealed:<br>-It indicated the start date of that PO for roflumilast was 5/2/23.<br>-Two-250 mg tablets were to have been given daily.<br>-It indicated the start date of that PO for tamsulosin was 5/1/23.<br>-That medication had been scheduled to have been given at 8:00 a.m.<br><br>Interview on 9/26/23 at 7:45 a.m. with CMA N regarding the observed medication administrations referred to above revealed she:<br>*Had recognized the discrepancy between the prescription label and the MAR for resident 23's roflumilast after it had been pointed out to her.<br>-Believed the MAR order superseded the prescription label instructions.<br>*Was unsure if there was a medical reason for his tamsulosin to have been given in the morning versus another time of the day.<br><br>Interview on 9/26/23 at 1:40 p.m. with director of nursing B regarding the above medication administrations and the correct labeling revealed she:<br>*Expected medication prescription labels had | F 761 | All monitoring will be completed through interview, chart review or observation and documented on audit forms 2 days a week with random number of 2-5 sampled residents with medication changes and random number of 2-5 staff who administer medications a week and rotated to various shifts unless otherwise specified. Audits will increase or decrease days or number of residents based upon findings of audits, as determined by LNHA and IDT, and until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 2 months. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed. | |

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| F 761 | Continued From page 34<br>been checked against the PO on the MAR for any discrepancies prior to administration of the medication.<br>*If there was a discrepancy:<br>-CMAs were responsible for reporting that to a licensed nurse.<br>-The nurse was responsible for comparing the original PO for that medication against the order that had been entered on the MAR to verify the MAR accuracy.<br>-A change order sticker was applied to the prescription medication container and the pharmacy was notified so a new container with the accurate labeling was provided.<br><br>Review of the Quarter 3, 2022 Administering Medications policy revealed:<br>"7. The individual administering the medication must check the label carefully to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication."<br><br>Review of the 5/10/22 Medication Ordering and Receiving From Pharmacy policy revealed:<br>"G. 1. If the physician's directions for use change or the label is inaccurate, the nurse may place a 'change of order-check chart' label on the container indicating there is a change in directions for use, taking care not to cover important label information.<br>2. When such a label appears on the container, the medication nurse checks the resident's medication administration record (MAR) or the physician's order for current information.<br>3. The dispensing pharmacy is informed prior to the next refill of the prescription so the new container will contain an accurate label and quantity." | F 761 | | |

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| F 812 SS=D | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, job description review, and policy review, the provider failed to maintain two of two kitchens and food serving areas (main dining room and the Bistro) in a clean and sanitary manner. Findings include:<br><br>1. Observation on 9/25/23 at 10:15 a.m. of the main dining room revealed:<br>*The baseboard along the side of the counter where the beverage dispensers were located (nearest to the serving area) was missing.<br>*The length of the baseboard along the wall between that same counter that extended towards the serving area was colored with brown and white build-up of unknown origin.<br>*The inside of the microwave in the serving area | F 812 | Corrective Action<br>Main dining room baseboard was fixed on 10/16/2023. Main dining room counter, microwave, white tub, and gray tub were cleaned on 10/12/2023.<br><br>Bistro counters, drawers, cabinet, sink, serving counter, and green container were cleaned on 10/16/2023.<br><br>Identification of Others<br>All areas of food preparation and storage are at risk of having unclean and unsanitary conditions.<br><br>Human Resources Manager reviewed all areas of food preparation and storage in main dining room and bistro and did complete cleaning of all areas identified unclean on 10/12/2023.<br><br>Systemic Changes<br>LNHA reviewed all current dietary cleaning logs and approved and updated all dietary cleaning logs to include counters, drawers, microwave, storage tubs and sinks. Dietary daily tasks reviewed and updated to include cleaning.<br><br>Human Resources Director reviewed dietary staffing and scheduling and updated dietary schedule to include scheduled cleaning days by 10/31/2023. | 10/31/2023 |

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| F 812 | Continued From page 36<br>had:<br>-Brown build-up of unknown origin inside the seams of the back corners, along the length of the back seam and upwards towards the top of the inside of that unit.<br>-Dark brown stains on the turntable.<br>-Brown smatterings on the interior top surface of that microwave.<br><br>*In the food serving area of the main dining room:<br>-A white plastic tub beneath the microwave was half-full of plastic coffee cups and bowls.<br>--Cook Q exited the kitchen and emptied additional cups and bowls into that same container.<br>--Light brown and other colored flecks of unknown origin were seen in the unobstructed areas at the bottom and around the perimeter of that tub.<br>-A gray plastic tub sat next to the steam table that contained metal plate guards.<br>--Guards from that tub were used by cook R during the meal service.<br>-- Light-brown and other colored flecks of unknown origin were seen in the unobstructed areas at the bottom and around the perimeter of that tub.<br><br>2. Observation on 9/25/23 at 11:20 a.m. and again at 12:20 p.m. in the Bistro kitchen revealed:<br>*The countertop between the juice dispenser and water machine was stained with a light red-color.<br>-There were two separate brown sticky areas including one rectangle-shaped area approximately twelve inches by four inches in size.<br>*Beneath the juice dispenser:<br>-The rim of the inside frame of the drawer and the bottom of that drawer was spotted with | F 812 | LNHA or designee will provide education to dietary manager and dietary staff on Sanitation Policy and reporting maintenance repair requests using facility TELS program.<br><br>Education will be completed by 10/31/2023.LNHA will ensure, through staff listing, of completed education with staff signature. Those who have not received education by 10/31/2023 will be reported to department manager they require to be educated prior to next working shift.<br><br>Monitoring<br>LNHA or designee will monitor through observation, interview, cleaning logs and scheduling to ensure all areas in dietary are cleaned regularly per schedule that include food preparation and storage areas.<br><br>All monitoring will be completed through interview, chart review or observation and documented on audit forms 2 days a week. Audits will increase or decrease days based upon findings of audits, as determined by LNHA and IDT, and until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 2 months. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed. | |

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| F 812 | Continued From page 37<br>brown-colored sticky areas.<br>-The cabinet beneath that same drawer was also spotted with brown-colored sticky areas.<br>*The stainless-steel kitchen sink was water and coffee-stained and had areas along the sides of it that had dried white flakes adhered to it.<br>*The counter in front of the serving window had no less than six areas of what appeared to have been coffee stains.<br>*A green plastic container on the serving counter had contained napkin-rolled silverware.<br>-Laid on top of that silverware had been paper menus completed for the meal service.<br>-Brown-stained spots and loose light-colored flakes of unknown origin were seen in the unobstructed areas at the bottom and around the perimeter of that container.<br><br>Interview on 9/26/23 at 8:30 a.m. with cook R revealed kitchen, dining, and serving area cleaning responsibilities and schedules had been posted in the main kitchen area.<br><br>Review of the cleaning schedules referred to above revealed:<br>*Separate schedules hung on the wall for fourteen different kitchen, dining, and serving area cleaning tasks.<br>-The frequency of those tasks occurred either weekly, bi-weekly, or monthly.<br>*There were specific tasks for cleaning the Bistro drawers and cabinets and cleaning of the dining room walls should have occurred every two weeks.<br>*There were no tasks related to the cleaning of the counters, microwaves, or the sinks.<br><br>Interview on 9/26/23 at 4:30 p.m. with administrator A and director of nursing B revealed | F 812 | | |

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| F 812 | Continued From page 38<br>they had expected:<br>*Countertops, sinks, serving areas, and kitchen equipment to have been cleaned and disinfected between each meal service.<br>*Cabinet drawers and surfaces should have been cleaned and disinfected as needed and according to the schedule referred to above.<br>*A work order had been submitted for the missing baseboard in the main dining room.<br>*Dietary supervisor H had periodically audited the dining rooms, kitchens, and serving areas to ensure the cleaning had occurred.<br>-She was not been available on 9/26/23 to have participated in the interview.<br><br>Review of the undated Dietary Supervisor job description revealed:<br>*Food Preparation, Delivery and Cleaning Responsibilities:<br>-"Take out trash; sweep and mop floors in main dining room, kitchen, and pantry; wipe pantry shelves; scrub baseboards and walls as needed; clean appliances, equipment, freezers, etc; always leave kitchen clean and orderly."<br><br>Review of the revised October 2008 Sanitization policy revealed:<br>"2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use of proper cleaning."<br>*"17. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignments." | F 812 | | |

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| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to: | F 880 | Corrective Action<br>Staff S and Staff J reported to DON on 10/16/2023 they had received education from surveyor at time of survey. DON or designee will complete a hand hygiene competency for Staff S and staff J on 10/16/2023.<br><br>DON completed hand hygiene competency on Staff S and Staff J on 10/17/2023.<br><br>Identification of Others<br>All residents being served a meal have potential impact for lack of appropriate processes and follow through for risk of cross contamination due to improper hand hygiene and expired hand sanitizer and bleach wipes.<br><br>DON or designee will complete education and hand hygiene competency on all dietary staff and therapy staff on or before 10/31/2023 or prior to next shift worked after.<br><br>LNHA assigned Central Supply to review all hand sanitizer in facility for expiration and replace if needed on or before 10/31/2023.<br><br>LNHA assigned all department managers to review entire departments for expired cleaning wipes and discard on 10/31/2023. | 10/31/2023 |

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| F 880 | Continued From page 40<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to ensure infection prevention and control practices were implemented for the following:<br>*Proper use of hand sanitizer gel in three of three resident dining areas.<br>*Proper use of sanitizing clothes in one of one resident dining area.<br>*Appropriate hand hygiene by one of one dietary aide (J) and one of one speech therapist (ST) (S) during one of one observed meal service. | F 880 | Systemic Changes<br>Handwashing instructions will be posted at sinks in dining areas on or before 10/31/2023.<br>Resident hand wipes are provided in all dining areas to assist with resident hand hygiene before and after meals as desired.<br><br>DON or designee will provide education to all staff on hand washing and hand hygiene policy.<br><br>LNHA will provide education to Human Resource Director (HR) to include hand washing competency for all new hire or transferred staff to be completed during orientation and training period and to monitor and track for all staff to complete a hand washing competency yearly.<br><br>LNHA will provide education to Central Supply to check hand sanitizer and cleaning wipes monthly in all common areas not identified as resident rooms.<br><br>LNHA will provide education to Housekeeping Manager to check hand sanitizer and wipes in resident rooms, resident hallways and housekeeping and laundry departments monthly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435035 | A. BUILDING _____ B. WING _____ | 09/27/2023 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 880 | Continued From page 41<br>Findings include:<br><br>1. Observation on 9/25/23 between 10:15 a.m. and 10:30 a.m. and again between 12:00 p.m. and 12:20 p.m. of the dining rooms and food serving areas revealed:<br>*In the assisted dining room adjacent to the main dining room:<br>-A partially-full 64-ounce (oz) container of Purell hand sanitizer with an expiration date of July 2023 sat near one of the dining tables.<br>--"Do Not Throw Away" had been handwritten on that dispenser.<br>--The pump on that dispenser had light-brown stains of unknown origin on it.<br>*In the main dining room:<br>-A partially-full 64 oz container of Purell hand sanitizer with an expiration date of May 2023 sat on one of the dining tables.<br>--"Do Not Throw Away" had been handwritten on that dispenser.<br>-A bleach wipe dispenser had an expiration date of November 2022 and sat on a counter.<br><br>2. Observation on 9/25/23 between 12:00 p.m. and 12:15 p.m. in the main dining room revealed:<br>*Speech therapist (ST) S served residents their meals and assisted them with meal-related needs.<br>*Performed handwashing between each resident.<br>-After rinsing off her cleaned hands with water she used her wet hands to turn the blade handles of the faucet off before drying her hands with a paper towel.<br><br>Interview on that same date and time with ST S revealed she was not aware she should not have touched the blade handles with her wet hands to lessen the chance of cross-contamination. | F 880 | LNHA, IDT and Medical Director reviewed and approved Handwashing/Hand Hygiene policy. LNHA or designee will provide education to all staff participating in meals on Handwashing/Hand Hygiene policy to include using a towel to turn off faucet.<br><br>Education will be completed by 10/31/2023.LNHA will ensure, through staff listing, of completed education with staff signature. Those who have not received education by 10/31/2023 will be reported to department manager they require to be educated prior to next working shift.<br><br>LNHA will provide education to all department managers on new hire staff or transferred staff of the manager expectations to ensure education and training is completed on handwashing during the new or transferred staff's orientation period, prior to being released from orientation or training.<br>A Root Cause Analysis was completed by LNHA, DON, IF and IDT and reviewed with Medical Director. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 435035 | A. BUILDING _____ B. WING _____ | 09/27/2023 |

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

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| F 880 | Continued From page 42<br><br>3. Continued observation 9/25/23 between 12:20 p.m. and 12:30 p.m. in the Bistro food service area revealed:<br>*Dietary aide J served residents their meals and assisted them with meal-related needs.<br>*Performed handwashing between each resident.<br>-After rinsing off her cleaned hands she used those wet hands to turn the blade handles of the faucet off before drying her hands with a paper towel.<br><br>Interview on that same date and time with dietary aide J revealed she was not aware she should not have touched the blade handles with her wet hands to lessen the chance of cross-contamination.<br><br>Interview on 9/26/23 at 4:30 p.m. with administrator A, director of nursing B and infection control nurse/staff scheduler E regarding the observations referred to above revealed:<br>*The 64 oz hand sanitizer dispensers should have been removed and no longer used.<br>-Other alcohol-based hand sanitizer options should have been used.<br>*Housekeeping staff were responsible for ensuring disinfectant wipes had not expired.<br>*ST S and dietary aide J had not followed the expected procedure for proper hand washing.<br><br>Review of the revised October 2018 Infection Control policy revealed:<br>"2. The objectives of our infection control policies and practices are to:"<br>-"b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public;" | F 880 | Results were reviewed by LNHA and DON with SD Quality Improvement Organization on 10/17/2023. The systemic changes and corrections reflect the findings and recommendations. The facility found root cause for deficiency to be related to Dietary Manager, Rehabilitation Director, and Human Resources Director turnover.<br>In addition, during COVID pandemic, facility did place hand sanitizer and sanitizing wipes throughout facility for easy accessibility for increase cleaning during Covid outbreaks. The facility discovered through RCA areas that these items are not frequently used in all areas where they were placed.<br><br>Monitoring<br>DON or designee will complete monitoring through observation and interview of handwashing to ensure proper handwashing to prevent cross contamination.<br><br>LNHA or designee will complete monitoring through observation, documentation review, and interviews to ensure facility is free from expired hand sanitizer and sanitizing wipes.<br><br>LNHA or designee will complete monitoring through orientation files, interviews, and observation to ensure new staff are receiving hand washing competency and training during orientation and training period. | |

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| | 435035 | A. BUILDING _____ B. WING _____ | 09/27/2023 |

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

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| F 880 | Continued From page 43<br>Review of the revised August 2019 Handwashing/Hand Hygiene policy revealed:<br>*"7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations:"<br>"-p. Before and after assisting a resident with meals;"<br>*Hand Washing Procedure:<br>-"3. Rinse hands with water and dry thoroughly with a disposable towel.<br>-4. Use towel to turn off the faucet." | F 880 | All monitoring will be completed through interview, chart review or observation and documented on audit forms 2 days a week with random number of 2-5 sampled staff a week and rotated to various shifts unless otherwise specified. Audits will increase or decrease days or number of residents based upon findings of audits, as determined by LNHA and IDT, and until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 2 months. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435035 | A. BUILDING _____ B. WING _____ | 09/27/2023 |

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

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| E 000 | Initial Comments<br><br>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 9/25/23 through 9/27/23 . Rolling Hills Healthcare was found in compliance. | E 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: T Harwood
TITLE: Licensed Nursing Home Administrator
(X6) DATE: 10/20/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

South Dakota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10594 | A. BUILDING: _____ B. WING _____ | 09/27/2023 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| S 000 | Compliance/Noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/25/23 through 9/27/23. Rolling Hills Healthcare was found not in compliance with the following requirements: S290 and S301. | S 000 | | |
| S 290 | 44:73:07:05 Food Supply<br><br>The facility shall maintain an on-site supply of perishable and nonperishable foods adequate to meet the planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of their emergency preparedness plan. Military meals ready to eat (MRE) are not a substitute for the nonperishable food supply for residents, but may be used to address other emergency food supply needs.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation, interview, and policy review, the provider failed to maintain a food supply sufficient to provide meals for three days and an additional food supply in case of an emergency. Findings include:<br><br>1. Observation and interview on 9/25/23 at 11:00 a.m. with dietary supervisor H in the emergency food supply storage area revealed:<br>*She had been in her current position since November 2022.<br>*The emergency food supplies that were observed in that area had been limited and included the following:<br>*Four-26 oz (ounce) bags of cereal, 200 packets of graham crackers, 500 packets of Saltine crackers, two boxes of cookies, six-6 lb (pound) cans of pudding, and two-6 lb cans of peaches | S 290 | Corrective Action<br>The current emergency food supply was removed from stock. A food order has been completed on 10/17/2023 to provide adequate supply based on facility's emergency menu as provided by US foods.<br><br>Identification of Others<br>All residents are at risk of not having adequate nutrition in the event of an emergency.<br><br>Systemic Changes<br>Administrator, IDT, Registered Dietician and Medical Director reviewed and approved emergency menu provided by US Foods '7-day Disaster Menu.'<br><br>A checklist has been created for monthly inventory of emergency food supply to ensure adequate 3-day supply is available and ensure rotation supply prior to expiration and restock of supply as needed.<br><br>Administrator, IDT, Registered Dietician and Medical Director did | 10/31/2023 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: THarwood — TITLE: Licensed Nursing Home Administrator — (X6) DATE: 10/20/2023

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10594 | A. BUILDING: _____ B. WING _____ | 09/27/2023 |

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

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| S 290 | Continued From page 1<br>and pears, and 200-1.5 oz containers of peanut butter.<br>*There were an unidentified number of standard-sized cans of the following pureed food: green beans, corn, beef stew, and beef lasagna.<br>-She was unable to locate expiration dates on those cans of pureed foods.<br>*The emergency food supply on hand had not:<br>-Been sufficient in quantity to have provided meals for three days and an additional food supply in case of an emergency.<br>-Met the nutritional needs of the residents during an emergency.<br>-All been of a consistency that would have been palatable to most of the residents.<br>*Dietary supervisor H had no knowledge of what types of food and the quantity of food she should have had on hand for an emergency food supply.<br>-She had not thought to have discussed the food needs for an emergency food supply with the facility's registered dietician consultant.<br><br>Review of the undated Dietary Considerations for Residents policy revealed:<br>*"2. A disaster menu shall be developed and this emergency menu shall be updated regularly based on the needs of the residents."<br>*"4. A minimum of food and water to last for seven days shall be maintained at the facility in a specific location. This minimal amount of food and water should be determined based on the number of residents, employees and visitors during a crisis or disaster situation."<br><br>Review of the revised 10/26/15 Sample Emergency Meal Plan for Three Days received from administrator A on 9/26/23 at 5:25 p.m. that was referenced to in the policy referred to above revealed:<br>*The following food had been included in those | S 290 | amend Dietary Considerations for Residents Policy to ensure facility maintains a food supply sufficient to provide meals for three days with additional three-day emergency food supply. Administrator will provide education to dietary manager prior to returning to work on the facility disaster/emergency menu and SD Administrative Rules for Emergency food supply.<br><br>Administrator or designee will provide education to all dietary staff on use of emergency food supply and appropriate rotation of the emergency food supply as needed.<br><br>All education will be completed no later than 10/31/2023. Those who have not received education will be educated prior to next shift worked.<br><br>Monitoring<br>Administrator or designee will monitor emergency supply of food, monthly checklist, and staff knowledge of emergency supply of food.<br><br>Monitoring will be conducted 2-3 weekly and monitoring of checklist will be conducted monthly until a lessor frequency is deemed appropriate | |

South Dakota Department of Health

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| | 10594 | A. BUILDING: _____ B. WING _____ | 09/27/2023 |

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| ROLLING HILLS HEALTHCARE | 2200 13TH AVE BELLE FOURCHE, SD 57717 |

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| S 290 | Continued From page 2<br>meal plans: canned soups, tuna, chicken, and ham as well as nutritional supplements.<br>-Those foods had not been a part of the emergency food supply currently on hand. | S 290 | by the QAPI committee for a minimum of 2 months. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed. | |
| S 301 | 44:73:07:16 Required Dietary Inservice Training<br><br>The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on personnel record review, training record review, interview, job description review, and policy review, the provider failed to ensure required dietary training (food safety, handwashing, food handling and preparation, foodborne illness, serving and distribution procedures, leftover food handling, time and temperature controls for food preparation and services, nutrition, hydration and sanitation) had been offered and completed on an ongoing basis for two of four sampled dietary staff (I and J). Findings include:<br><br>1. Interview on 9/25/23 at 11:00 a.m. with dietary supervisor H regarding the required dietary training revealed:<br>*The facility used a computer-based program called Relias to ensure dietary staff had received the ongoing required dietary training referred to above. | S 301 | Corrective Action<br>All required dietary training defined in SD Administrative Rules was provided to all dietary staff during survey.<br><br>Identification of Others<br>All residents are at risk for food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration and sanitation from.<br><br>Systemic Changes<br>Administrator will provide education to dietary manager on facility orientation for new hires and transfers including department manager responsibility for ensuring adequate orientation with required dietary in-service training to all new hires and transfers.<br><br>All education will be completed no later than 10/31/2023 or prior to working next shift. | 10/31/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 10594 | A. BUILDING: _____ B. WING _____ | 09/27/2023 |

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| S 301 | Continued From page 3<br><br>-Staff were notified of their assigned training by e-mail then logged into Relias to complete them.<br>*Human resource (HR) coordinator G was responsible for letting her know of incomplet dietary training for her to follow-up on.<br><br>Review of dietary aide I and J's Relias training records with HR coordinator G revealed:<br>*Dietary aide I's hire date was 8/3/22.<br>*She had been assigned the Food Safety Fundamentals training to complete.<br>-The content in that training included eight of the nine required dietary training topics referred to above.<br>-The due date for completion of that training was 5/31/23 but that training had not been started.<br>*She had not been assigned the Understanding Nutrition and Hydration training.<br>-That training would have met the requirement for the ninth required dietary training topic not covered in the Food Safety Fundamentals course.<br>*Dietary aide J's hire date was 6/30/23.<br>*She had been assigned Food Safety Fundamentals and that training had not been started.<br>*She had been assigned Understanding Nutrition and Hydration.<br>-The due date for completion of that training was 8/31/23 and it had not been started.<br>*She had received no documented dietary-related Relias training since her hire date.<br><br>Interview on 9/25/23 at 3:45 p.m. with administrator A and HR coordinator G revealed:<br>*The facility's New Hire Information packet was supposed to have included the required dietary training topics information.<br>-Dietary supervisor H was responsible for having trained her newly hired dietary employees using | S 301 | Monitoring<br>Administrator or designee will monitor new hire or transferred dietary staff to ensure training and required education is completed prior to being released from orientation or training.<br><br>Monitoring will be completed 2-3 times weekly until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 2 months. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 10594 | A. BUILDING: _____ B. WING _____ | 09/27/2023 |

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| S 301 | Continued From page 4<br><br>that information.<br>*Administrator A had not been aware that dietary supervisor H was not following that expectation.<br>*Dietary supervisor H in conjunction with HR coordinator G had been responsible for ensuring dietary employees completed ongoing dietary-related Relias training and that had not occurred.<br><br>Interview on 9/25/23 at 4:50 p.m. with dietary aide J revealed:<br>*Her dietary training had been "on the job training".<br>*Dietary supervisor H had not reviewed any of the required dietary training topics referred to above with her.<br>*She was aware of the Relias training program but had not completed any dietary-related Relias trainings that had been assigned to her.<br><br>A Dietary Inservice Training policy was requested from administrator A on 9/26/23 at 9:00 a.m. An undated "Orientation Program for Newly Hire Employees, Transfers, Volunteers" policy was provided which stated "...each department orients the newly hired employee/transfer/volunteer/contractor to his or her department's policies and procedures, as well as other data that will aid him/her in understanding the team concept, attitudes and approaches to resident care."<br><br>Review of the undated Dietary Manager job description included the following responsibility: "Ensure that the department adheres to State and Federal regulations." | S 301 | | |
| S 000 | Compliance/Noncompliance Statement | S 000 | | |

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| S 000 | Continued From page 5<br>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 9/25/23 through 9/27/23. Rolling Hills Healthcare was found in compliance. | S 000 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 435035 | A. BUILDING **01 - MAIN BUILDING 01** B. WING _____ | **09/26/2023** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 000 | INITIAL COMMENTS<br><br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/26/23. Rolling Hills Healthcare was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.<br><br>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 providers commitment to continued compliance with the fire safety standards. | K 000 | | |
| K 712 SS=C | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation 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.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the provider failed to ensure staff were familiar with the provider's fire drill procedures (removing residents from the corridor and training). Findings include:<br><br>1. Observation on 9/26/23 at 3:10 p.m. revealed | K 712 | Corrective Action<br>Administrator provided verbal education during survey to staff member finding fire simulation of fire drill procedure.<br><br>Identification of Others<br>100% of building occupants at risk. Past 6-month fire drills will be reviewed to ensure all staff hired prior to 9/25/2023 have or will participate in a fire drill by 10/31/2023<br><br>Systemic Changes<br>All new staff will be educated on facility Fire Drill procedure before being released from orientation and training.<br><br>All new staff will participate in a fire drill within the first 90 days of hire. | 10/31/2023 |

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

T Harwood

TITLE: Licensed Nursing Home Administrator

(X6) DATE: 10/20/2023



Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435035 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **09/26/2023** |

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

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| K 712 | Continued From page 1<br>the staff member responding to the call light for room 204 entered the room with the simulated fire. Upon recognizing that a fire drill was being initiated, the staff member entered the corridor and asked the maintenance supervisor what to do. He replied he could not help with the drill. The staff member then radioed for help and another person pulled a manual fire alarm station. During the course of the drill, several staff responded with fire extinguishers in hand and shut corridor doors. The resident who was in room 204 at the onset of the drill was left in the corridor throughout the simulated drill.<br><br>2. Interview with the staff member responding to the call light stated she had been an employee for nine months and had not participated in a fire drill to that point. Several other staff who were present for the fire drill commented they were new employees within the past year and had not participated in a fire drill.<br><br>3. Review of the fire drill scheduling revealed the provider had the minimum number of fire drills scheduled for 2023: one per shift per month, starting with the first shift in January, a second shift in February, and a third shift in March (then repeating the cycle).<br><br>4. Interview on 9/26/23 at 3:35 p.m. with the administrator revealed there were a large number of new employees in the past year, and fire drill training consisted of a new employee indoctrination, annual all-staff training, and the scheduled fire drills. The need for additional training for new employees was discussed.<br><br>The deficiency had the potential to affect 100% of the building occupants. | K 712 | Administrator or designee will provide all staff education on facility fire drill procedure.<br><br>Administrator will provide education to Maintenance Director to review Fire Drill procedure with all new staff during orientation and to ensure all new staff participate in a fire drill within 90 days of hire.<br><br>Administrator will provide education to Human Resources to ensure all new hires are provided with orientation with Maintenance Director prior to being released from orientation or training.<br><br>All education will be completed no later than 10/31/2023.Those who have not received education will be educated by 10/31/2023 will be educated prior to their first shift worked after.<br><br>Monitoring<br>Administrator or designee will monitor new staff and current staff on fire drill procedures to ensure all new staff have participated in a fire drill in the first 90 days of hire.<br><br>Monitoring will be conducted monthly until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 2 months. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed. | |

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