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 _____ | 09/08/2022 |

| 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 9/7/22 through 9/8/22. Rolling Hills Healthcare was found not in compliance with the following requirements: F658 and F880. | F 000 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to ensure one of one unlicensed assistive personnel (UAP) (C) had followed the provider's policies when administering medication to six of six (8, 15, 17, 19, 26, and 44) residents. Findings include:<br><br>1. Observations on 9/7/22 between 1:30 p.m. and 1:52 p.m. of UAP C revealed he:<br>*Administered eye drops individually to residents 15, 19, and 26.<br>*Verbally prompted them to tilt their heads back slightly before instilling their eye drops in the innermost corners of their eyes.<br><br>Interview on 9/7/22 at 4:10 p.m. with UAP C regarding the above observations revealed that was his usual practice for eye drop administration.<br><br>Review of the provider's Quarter 3, 2018 | F 658 | Corrective Action:<br><br>DON verified with UAP C on 9/21/2022 that education was given to UAP C by surveyor on instilling eye drops by pulling the lower eyelid down, instruct resident to look up and drop the medication into the mid lower eyelid. DON completed a competency on UAP C for application of Eye Drops on 9/21/2022.<br><br>DON provided education to UAP C on Administering Medication Policies to ensure medication administration documentation is completed after giving a medication with correct date and time the medication was administered, and ensuring medications are administered in accordance with the order, including any special needs of the resident for the order. DON completed a medication administration competency with UAP C on 9/21/2022.<br><br>DON verified with UAP C on 9/21/2022 that education was given to UAP C by surveyor of special need instructions for resident 44's inhaler. DON completed a competency with UAP C on administering medications through a metered dose inhaler on 9/21/2022. Education provided to UAP C on 9/21/2022 includes reviewing any instructions associated with a medication prior to administering that medication. | 09/29/2022 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

T Harwood, Administrator | 9/29/2022

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 658 | Continued From page 1<br>Instillation of Eye Drops policy revealed:<br>*Steps in the Procedure:<br>-"7. Gently pull the lower eyelid down. Instruct the resident to look up."<br>-"8. Drop the medication into the mid lower eyelid (fornix)."<br><br>2. Observation and interview on 9/7/22 at 1:47 p.m. with UAP C in resident 8's room revealed he:<br>*Entered the room with a medication cup containing Maalox and was instructed by that resident to leave the cup on her bedside stand.<br>*Left that room without ensuring she had taken that medication.<br>*Stated she had a history of refusing her medications as well as hoarding them in her room.<br><br>Review of resident 8's care record revealed she had been assessed and was able to self-administer only her nebulizer treatment.<br><br>Review of resident 8's September 2022 Medication Administration Record (MAR) revealed:<br>*UAP C had documented the Maalox had been administered by him at 1348 (1:48 p.m.) on 9/7/22.<br>*There was an order: "Witness medication administration every shift" (morning, afternoon, and evening shifts). The start date was 10/28/21.<br>-That was checked off as completed by UAP C for medications he administered on the 9/7/22 afternoon shift.<br><br>Interview on 9/8/22 at 2:15 p.m. with UAP C regarding the observation above revealed he:<br>*Documented on resident 8's MAR that she had taken her Maalox, but had not witnessed her | F 658 | DON verified with UAP C on 9/21/2022 that education was given to UAP C by surveyor to discard the first drop of blood if alcohol is used to clean the fingertip because alcohol may alter the results. DON completed a Fingerstick glucose level competency on 9/21/2022.<br><br>DON verified resident 15 had no noted complications from incorrect eye drop administration. DON verified resident 19 had no noted complications from incorrect eye drop administration. DON verified resident 26 had no noted complications from incorrect eye drop administration. DON verified resident 8 had no noted complications from missed witness of medication administration. DON verified resident 44 had no noted complications from missed mouth rinse after inhaler administration. DON verified resident 17 had no noted complications from missed wipe of first blood prior to blood glucose reading.<br><br>Identification of Others:<br><br>DON or Designee reviewed all residents with current eye drop orders to ensure no negative side effects noted due to improper instillation of eye drops.<br><br>DON reviewed all residents with special need orders relating to inhalers and medication administration with no noted complications.<br><br>DON reviewed all residents with blood glucose level checks with no noted complications. | |

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| F 658 | Continued From page 2<br>consume it.<br>-Should not have documented he administered the Maalox.<br><br>Review of the provider's Quarter 3, 2018 Administering Medications policy revealed:<br>*"19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones."<br>*"20. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered;"<br>*"24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely."<br><br>3. Observation on 9/7/22 at 2:20 p.m. of UAP C administering resident 44's Symbicort inhaler revealed he had shaken the inhaler, administered the ordered number of puffs to the resident, and left his room.<br><br>Review of resident 44's September 2022 MAR revealed instructions for administering the Symbicort inhaler included providing the resident water to rinse his mouth after inhaler use before spitting that water out.<br><br>Interview on 9/8/22 at 2:15 p.m. with UAP C regarding the observation above revealed he:<br>*Was unaware of the administration instructions referred to above for resident 44's inhaler.<br>*Was aware of another resident who specifically requested to "swish and spit" after she had received her inhaler. | F 658 | Systemic Changes:<br><br>Administrator, DON, IDT (Interdisciplinary Team), and Medical Director reviewed and approved Instillation of Eye Drops Policy, Administering Medications Policy and Obtaining a Fingerstick Glucose Level Policy.<br><br>DON or Designee will educate licensed nurses, and licensed medication aides on the facility's Instillation of Eye Drops Policy, Administering Medications Policy and Obtaining a Fingerstick Glucose Level Policy. Education will include to ensure the eye drop administration is performed by pulling the lower eyelid down and dropping the medication into the mid lower eyelid, to ensure medications are administered in accordance with the order, to ensure medication administration is documented after giving a medication with appropriate date and time, and residents are able to self-administer medications only if physician, IDT and care planning has determined the resident has the decision-making capacity to do so safely, and to wipe away first drop of blood if alcohol is used to clean the fingertip. Education will be completed no later than 9/29/2022. Those who have not received the education by 9/29/2022 will be educated prior to their first shift worked after.<br><br>Monitoring:<br><br>DON or Designee will monitor residents with eye drop orders to ensure licensed nurses and medication aids are administering eye drops by pulling the lower eyelid down and dropping the medication into the mid lower eyelid. Any concerns noted will be corrected immediately. | |

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| F 658 | Continued From page 3<br><br>Review of the provider's Quarter 3, 2018 Administering Medications policy revealed "3. Medications must be administered in accordance with the orders, including any required time frame."<br><br>4. Observation and interview on 9/7/22 at 4:10 p.m. with UAP C performing a blood glucose check for resident 17 revealed he:<br>*Cleaned her left index finger with an alcohol pad, allowed it to briefly air dry, and inserted the lancet into the center of the pad of that finger.<br>*Immediately took a blood glucose reading from the first blood that emerged from that finger.<br>*Had "always done it this way."<br>*Had not known that first blood was expected to be wiped from the finger and the blood glucose reading taken from the subsequent blood that emerged.<br><br>Review of the provider's Quarter 3, 2018 Obtaining a Fingerstick Glucose Level policy revealed:<br>*Steps in the Procedure<br>-"8. Obtain a blood sample by using a sterile lancet (a spring-loaded lancet or manual lancet). Discard the first drop of blood if alcohol is used to clean the fingertips because alcohol may alter the results."<br><br>Interview on 9/8/22 at 3:40 p.m. with administrator A and director of nursing B regarding the observations above revealed:<br>*Eye drops were expected to be administered into the center of a resident's lowered bottom eyelid.<br>*Resident 8's Maalox should not have been documented as administered by UAP C if he had not witnessed her take that medication. | F 658 | Monitoring will be conducted 3 times weekly through chart review, observation and interviews 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.<br><br>DON or Designee will monitor medication aides and nurses to ensure medications are administered in accordance with the order, medications are documented after giving the medication with appropriate time and date, and medications are only left with residents who have been care planned with orders to self-administer medications. Any concerns noted will be corrected immediately. Monitoring will be conducted 3 times weekly through chart review, observation and interviews 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.<br><br>DON or designee will monitor medication aides or nurses obtaining blood glucose to ensure the first drop of blood is wiped away if using alcohol to clean the fingertip. Any concerns noted will be corrected immediately. Monitoring will be conducted 3 times weekly through chart review, observation and interviews 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 658 | Continued From page 4<br>*Nursing staff were expected to review any instructions associated with a medication prior to administering that medication.<br>*First blood was expected to be wiped from a resident's finger prior to taking a blood glucose reading.<br>*Informal medication administration audits were completed to spot check medication administration practices and provide real time feedback as needed.<br>*UAP medication administration competencies had not been consistently done due to the pandemic, but that needed to resume as soon as possible. | F 658 | | |
| 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 | F 880 | Directed Plan of Correction:<br><br>Corrective Action:<br><br>For the identification of lack of:<br>*Appropriate hand hygiene and glove use by UAP C when administering eye drops: DON completed a glove use competency for UAP C on 9/21/2022. DON completed education to UAP C on 9/21/2022 for hand hygiene with glove use.<br>*Appropriate maintenance of wrist blood pressure cuff with an uncleanable surface and cleaning of multi-resident use equipment between residents. Administrator ordered new wrist blood pressure cuffs on 9/1/2022. Equipment was delivered to facility on 9/15/2022. Uncleanable wrist blood pressure cuff was replaced on 9/15/2022.<br><br>DON completed education to UAP C on 9/21/2022 on facility's Cleaning and Disinfection of Resident-Care Items and Equipment Policy. | 09/29/2022 |

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| F 880 | Continued From page 5<br>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:<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. | F 880 | Identification of Others:<br><br>ALL residents who receive eye drops and vital signs and all staff administering eye drops or obtaining vital signs have the potential to be affected by lack of:<br>*Appropriate hand hygiene and glove use when administering eye drops.<br>*Appropriate maintenance and cleaning of medical equipment between residents.<br><br>DON/Designee reviewed all vital sign equipment used by staff to ensure all equipment is maintained and has appropriate cleanable surfaces.<br><br>DON/Designee will complete a demonstrated competency and documentation with all direct care staff for hand hygiene with glove use and all staff responsible for obtaining vital sings for appropriate maintenance and cleaning of medical equipment between residents. Competencies will be completed by 9/29/2022. Those not completed by 9/29/2022 will be completed by their next worked shift.<br><br>Systemic Changes:<br><br>The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary, policies and procedures for Handwashing/Hand Hygiene Policy, Personal Protective Equipment-Using Gloves Policy, and Cleaning and Disinfection of Resident-Care Items and Equipment Policy. | |

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| F 880 | Continued From page 6<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, review of employee training records, job description review, and policy review, the provider failed to ensure infection prevention and control practices had been maintained for:<br>A. Proper glove use by one of one unlicensed assistive personnel (UAP) (C) prior to eye drop administration for three of three observed residents (15, 19, and 26).<br>B. Use of a blood pressure wrist cuff with an uncleanable surface by one of one UAP (C) between two of two observed residents (4 and 43).<br>C. Cleaning of shared vital signs equipment (thermometer, pulse oximeter, blood pressure cuff) by one of one UAP (C) between five of five observed residents (4, 5, 6, 43, and 50).<br>Findings include:<br><br>A. Observation on 9/7/22 between 1:30 p.m. and 1:52 p.m. of UAP C revealed:<br>*He administered eye drops to three residents (15, 19, and 26).<br>*Without performing hand hygiene, he put on gloves after entering each resident's room then administered their eye drops.<br><br>B. Observation on 9/7/22 between 2:40 p.m. and 2:45 p.m. of UAP C revealed he:<br>*Took resident 43's blood pressure with a blood pressure cuff that fit on her wrist.<br>-Used a Clorox wipe to clean that cuff after leaving her room. | F 880 | Administrator/DON or Designee will provide education to all facility staff who provide or are responsible for obtaining vital signs, all direct care staff for proper hand hygiene with glove use. Education will include roles and responsibilities of policies and procedures for Handwashing/Hand Hygiene Policy, Personal Protective Equipment-Using Gloves Policy, and Cleaning and Disinfection of Resident-Care Items and Equipment Policy. Education will be completed by 9/29/2022. Those not educated by 9/29/2022 will be educated prior to their next worked shift.<br><br>A Root cause analysis answering the 5 why's was completed by the interdisciplinary team (IDT) on 9/21/2022 with findings of: Staff are not aware how to request new vital sign equipment when maintenance/use of equipment resulted in uncleanable surfaces; staff don't have options to carry equipment; there is no designated area for clean equipment, staff confidence was low due to amount of time between med aide competencies.<br><br>Administrator/DON or Designee will educate direct care staff on proper way to request equipment when equipment maintenance/use has resulted in uncleanable surfaces; will educate staff to use vital sign totes/towers for clean equipment and where clean equipment can be stored. Education will be completed by 9/29/2022. Those not educated by 9/29/2022 will be educated prior to their next worked shift.<br><br>Administrator and DON obtained vital sign totes for staff to carry, transport, and store clean vital sign equipment. Vital sign towers ordered on 9/22/2022 for staff to use for clean equipment when delivered | |

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| F 880 | Continued From page 7<br>*The two halves of the unit affixed to the top of that cuff where the blood pressure reading showed were held together by a medical grade paper tape that was uncleanable.<br>-The normally white paper tape was gray from repeated touching and handling.<br><br>C. Continued observation on 9/7/22 between 2:45 p.m. and 2:55 p.m. of UAP C revealed:<br>*1. After leaving resident 43's room and using the same uncleanable blood pressure cuff he:<br>-Entered resident 4's room, took her blood pressure, wiped the blood pressure cuff with a Clorox wipe after using it, and placed it in his unclean smock pocket with his medication cart keys.<br>*2. He immediately walked into resident 50's room and:<br>-Removed a pulse oximeter from the same unclean smock pocket that held the blood pressure cuff and medication cart keys.<br>-After taking resident 50's pulse oximetry reading, wiped the oximeter with a Clorox wipe and returned it to his unclean smock pocket with the blood pressure cuff and medication cart keys.<br>*3. Proceeded to the outside of resident 6's room and:<br>-With his bare hands, pulled the back of the resident's pants up to reposition him in his wheelchair.<br>-Removed a thermometer from his unclean smock pocket that held the blood pressure cuff, pulse oximeter, and medication cart keys.<br>-Without cleaning the thermometer, he held it against the resident's forehead to take his temperature.<br>*4. Walked down the hallway, laid the pulse oximeter and thermometer on top of his uncleaned medication cart. | F 880 | Administrator and DON contacted the South Dakota Quality Improvement Organization (QIN) on 9/20/2022 and completed a review of F880 findings, root cause analysis and directed plan of corrected on 9/21/2022. Discussion included findings are not widespread among staff, facility understanding of quality improvement methodology demonstrated in root cause analysis. Mitigation efforts addressing findings cited were discussed including clean places for vital sign equipment and using code words between workers as reminders for handwashing and glove use. Discussion included Administrator's completion of AHCL 20-hour infection control course and facility enrollment for ICAR scheduled on 9/22/2022. Additional resources were given to Administrator and DON.<br><br>Monitoring:<br><br>Administrator/DON or Designee will monitor through staff interviews, of knowledge to request new vital sign equipment when maintenance/use of equipment has resulted in uncleanable surfaces. Administrator/DON or designee will conduct monitoring 3 times weekly through chart review, observation, and/or interviews until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 2 months. Any concerns identified will be corrected immediately. Administrator or designee will report any identified trends to QAPI Committee monthly and as needed. | |

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| F 880 | Continued From page 8<br>*5. Proceeded across the hall from his medication cart, removed the blood pressure cuff from his unclean smock pocket and took resident 5's blood pressure in that hallway.<br><br>Interview on 9/8/22 at 2:18 p.m. with UAP C regarding the observations above revealed he:<br>*Was aware hand hygiene was expected prior to glove use and had not done that.<br>*Agreed the taped blood pressure cuff was uncleanable and a cleanable blood pressure cuff should have been used.<br>*Understood the risk for contamination of shared resident vitals equipment by keeping them in an unclean smock pocket especially if they had not been cleaned between resident use.<br><br>Interview on 9/8/22 at 3:50 p.m. with administrator A and director of nursing/infection control nurse B regarding the observations above revealed:<br>*Infection prevention and control education and audits were ongoing.<br>*Hand hygiene and glove use was recently re-reviewed with all staff.<br>-That education included the expectation that hand hygiene was performed prior to glove use.<br>*They knew the condition of the blood pressure cuff referred to above, but had not removed it so it was no longer used.<br>*Reusable resident equipment was expected to be cleaned between resident use and smock pockets were not a clean storage space for shared vital signs equipment.<br><br>Review of UAP C's annual training record revealed in December 2021 he had received infection prevention and control training. | F 880 | Administrator/DON or Designee will monitor through observation and interviews, to ensure vital sign equipment is cleaned between residents and placed in clean areas when not in use. Administrator/DON or designee will conduct monitoring 3 times weekly through chart review, observation, and/or interviews until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 2 months. Any concerns identified will be corrected immediately. Administrator or designee will report any identified trends to QAPI Committee monthly and as needed.<br><br>Administrator/DON or Designee will monitor through observation and interviews to ensure proper hand hygiene with glove use. Administrator/DON or designee will conduct monitoring 3 times weekly through chart review, observation, and/or interviews until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 2 months. Any concerns identified will be corrected immediately. Administrator or designee will report any identified trends to QAPI Committee monthly and as needed. | |

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 _____ | 09/08/2022 |

| 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 |
|---|---|---|---|---|
| F 880 | Continued From page 9<br>Review of the revised May 2019 Certified Medication Aide job description revealed nursing duties included "use of infection control/prevention techniques in the rendering of care."<br><br>Review of the provider's Quarter 3, 2018 Handwashing/Hand Hygiene policy revealed use of an alcohol-based hand rub or soap and water was expected "before donning sterile gloves;".<br><br>Review of the provider's Quarter 3, 2018 Cleaning and Disinfection of Resident-Care Items and Equipment revealed "reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions." | F 880 | | |

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 _____ | 09/08/2022 |

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

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|---|---|---|---|---|
| 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 9/7/22 through 9/8/22. Rolling Hills Healthcare was found in compliance. | E 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: T Harwood, Administrator
TITLE
(X6) DATE: 9/29/2022

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.

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 01 - MAIN BUILDING 01<br>B. WING | 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ROLLING HILLS HEALTHCARE | 2200 13TH AVE<br>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 |
|---|---|---|---|---|
| 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 9/8/22. 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 K345 in conjunction with the providers commitment to continued compliance with the fire safety standards. | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: T Hawood, Administrator
TITLE
(X6) DATE: 9/29/2022

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 ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETE: |
|---|---|---|---|
| | 435035 | A. BUILDING: **01 - MAIN BUILDING 01** B. WING ___ | **9/8/2022** |

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

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| **K 345** | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and interview, the provider failed to maintain one of one fire alarm system as required. Findings include:<br><br>1. Record review on 9/8/22 at 1:45 p.m. revealed the annual fire alarm inspection report dated 1/12/22 did not list sensitivities for the ionization-type smoke detectors.<br><br>Ref: 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11<br><br>2. Interview with the maintenance supervisor at the time of the record review confirmed those findings. He stated the contractor who provided the testing only confirmed a pass or fail condition.<br><br>The deficiency affected 100% of the occupants. |

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 _____ | 09/09/2022 |

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

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|---|---|---|---|---|
| S 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 9/7/22 through 9/8/22. Rolling Hills Healthcare was found in compliance. | S 000 | | |
| S 000 | Compliance/Noncompliance Statement<br><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 9/7/22 through 9/8/22. Rolling Hills Healthcare was found in compliance. | S 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JHawood, Administrator — TITLE — (X6) DATE: 9/29/2022

STATE FORM 6899 QWLX11 If continuation sheet 1 of 1