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 _____	C 06/17/2021

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 000	INITIAL COMMENTS Surveyor: 40053 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/15/21 through 6/17/21. Rolling Hills Healthcare was found not in compliance with the following requirements: F580, F658, F755, F842, F849, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/15/21 through 6/17/21. Areas surveyed included Quality of Care and Nursing Services. Rolling Hills Healthcare was found not in compliance with the following requirement: F580.	F 000	Submission of this Response and Plan of Correction is not a legal admission that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 19 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580	Corrective Action: DON/Designee notified resident 13 family on 12/2/2020. Identification of Others: DON or Designee reviewed all residents with current changes in skin condition to ensure of resident or representative notification. Systemic Changes: Administrator, DON (Director of Nursing), IDT (Interdisciplinary Team), and Medical Director reviewed and approved Health, Medical Condition and Treatment Options, Informing Residents of Policy.	7/11/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: T Harwood
TITLE: Administrator
(X6) DATE: 7/9/2021

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 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Surveyor: 40788 Based on interview, record review, and policy review, the provider failed to ensure one of one sampled resident's (13) family member had been notified of a significant change regarding the condition of her skin. Findings include:	F 580	continued from Page 1. DON or Designee will educate licensed nurses, to include LPN F, on the facility's Health, Medical Condition and Treatment Options, Informing Residents of Policy to ensure the facility will provide notification to residents or representatives when there is a significant change in condition. Education will be completed no later than 7/11/2021. Those who have not received the education by 7/11/2021 will be educated prior to their first shift worked after. Monitoring: DON or Designee will monitor residents with changes in condition to validate residents or representatives are notified of a change in condition. 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. Any concerns identified will be corrected immediately. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed.	

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F 580	Continued From page 2 1. Review and interview on 6/16/21 at 5:00 p.m. with social services designee (SSD) (H) regarding resident 13's progress note documentation between 11/12/20 and 12/2/20 revealed: *She confirmed resident 13's son was her primary emergency contact and healthcare power of attorney. *11/16/20: A telephone care conference had occurred with resident 13's son. -No identified skin concerns had been identified or discussed during that conference. *11/16/20: Resident 13 had been diagnosed with a urinary tract infection (UTI) by a certified nurse practitioner. *11/17/20: An excoriation on resident 13's buttock had been identified. The area was cleaned and a dressing applied. A wound assessment on that same date described that buttock excoriation as a stage II pressure ulcer. -SSD H confirmed resident 13's son had not been notified of that information but should have been. *11/18/20: Resident 13's son was notified resident 13 had started an antibiotic for treatment of that UTI. *11/19/20: Resident 13's son was notified of a change in the provider's visitation policy. *11/24/20: Resident 13's son was notified resident 13 was admitted to a nearby acute care hospital with an elevated sodium level. *12/2/20: Resident 13's son was notified by DON B and SSD H of resident 13's readmission to the facility from the hospital. They advised him she had returned with pressure ulcers to her feet, legs, buttocks and mid back. The buttock wound had progressed to a stage III pressure ulcer. -SSD H confirmed this was the first notification resident 13's son had of her having any skin concerns.	F 580		

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F 580	Continued From page 3	F 580		

Surveyor 40053
2. Review of the 11/17/20 Weekly Wound Review sheet for resident 13 revealed:
*It had been the initial wound assessment for a pressure wound to her coccyx.
*The name, date, and time of the family member who was notified of the pressure ulcer had been left blank.
*The document had been signed on 11/17/20 by licensed practical nurse F.

Interview on 6/16/21 at 3:40 p.m. with administrator A and DON B regarding notification to resident 13's family member revealed:
*LPN F had completed the wound assessment and was responsible to fill the form out completely.
-That had included contacting her son and updating him related to her skin condition.
*Both administrator A and DON B's expectation would have been:
*LPN F would have filled out the Weekly Wound Review sheet completely and notified resident 13's son of the change in her skin condition.
-Notification should have taken place on 11/17/20.

Review of the provider's Qtr [quarter] 3, 2018 Health, Medical Condition and Treatment Options, Informing Residents of policy revealed:
*Policy Statement:
"Residents will be informed of their health, medical condition and options for treatment and/or care."
**2. The resident's Attending Physician, the facility's Medical Director, or the Director of Nursing Services will be responsible for informing the resident of his or her medical condition. Such

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F 580	Continued From page 4 information will include providing the resident with information about his/her: a. functional status." *"3. The person informing the resident/representative of his or her medical condition will present such information in a format, language and cultural context that the resident/representative can understand."	F 580		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Surveyor: 40053 Based on observation, interview, record review, and policy review, the provider failed to follow professional standards of nursing practice for: *One of one sampled resident's (37) who required enteral feedings gastric tube placement had been evaluated prior to use by one of one licensed practical nurse (LPN) F. *One wound cleanser bottle with a resident's name on it had not been used for another resident (23) and that information had not been removed by one of one LPN F. *One of one residents (23) skin tear treatment had been documented by one of one LPN F. *Revision of one of one sampled resident's (18) care plan to reflect pressure ulcer development, resolution, and re-occurrence of that same pressure ulcer.	F 658	*See F880 for Directed Plan of Correction Correction Action: DON provided verbal education to LPN F on 6/18/2021 regarding improper hand hygiene and ensuring Gastric Tube Placement prior to feeding or administration of medications. Resident 23's skin tear was assessed and has no signs and symptoms of infection from LPN F's improper hand hygiene and using another residents wound cleanser. Assistant DON assessed resident 37 to validate proper gastric tube placement on 6/15/2021. DON provided education to LPN F regarding Expiration dates and proper disposal of wound cleanser. Documentation was completed for skin tear to right elbow on 6/17/2021. An order for treatment was placed for Resident 23's right elbow skin tear. Care plan is updated for right elbow skin tear. Resident 18's care plan has been updated to reflect pressure ulcer development and resolution and reoccurrence with resolution of that same pressure ulcer.	7/11/2021

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F 658	Continued From page 5 Findings include: 1. Observation on 6/15/21 at 12:30 p.m. of LPN F while completing a medication pass for resident 37 revealed: *Resident 37 had a gastric tube for enteral feedings and medication administration. *An order for liquid acetaminophen and Jevity liquid. -The liquid acetaminophen could be mixed with the Jevity and given together. *LPN F gathered the medication and Jevity and without performing hand hygiene: -Raised the head of resident 37's bed. -Went into the residents bathroom and retrieved a pair of gloves and put them on. -Poured the Jevity and acetaminophen into the empty gravity fed bag hanging on the intravenous (IV) pole. -Ran the liquid through the tubing to remove the air. -Dropped the tubing cap onto the floor. -Removed her gloves and used hand sanitizer. -Left the resident's room to retrieve a new set of tubing. *Without performing hand hygiene she: -Put on gloves. -Opened the new set of tubing and retrieved the cap. -Placed the new cap on the tubing and hung it from the IV pole. -Lifted the shirt of the resident and opened the gastric tube cap. *Without checking placement of the gastric tube she removed the cap from the tubing on the IV pole and attached it to the residents gastric tubing. -She started the acetaminophen and Jevity mixture which began running to the resident.	F 658	Continued from page 5 Identification Of Others: DON or Designee reviewed all residents with skin concerns to include skin tears, to ensure complete documentation of concern, treatment documentation is placed, the care plan is updated and resident or representative have been notified. All residents have the potential to be at risk if staff do not adhere to appropriate hand hygiene and appropriate maintenance and disposal of wound cleanser spray. Residents with wound treatments and gastric tubes were assessed for having appropriately labeled and unexpired wound care supplies and for signs and symptoms of infection related to missed hand hygiene opportunity. No issues were identified. Wound cleanser bottles were reviewed to validate individual resident labeling with expiration date labeled and found to be in compliance. All residents with gastric tubes were assessed to validate proper tube placement on 6/15/2021. Systemic Changes: Administrator, DON, IDT and Medical Director reviewed and approved the following facility policies/competencies: Hand washing/Hand Hygiene Policy, Enteral Feedings-Safety Precautions Competency, Charting and Documentation Policy, and Care Plans, Comprehensive Person-Centered Policy.	

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F 658	Continued From page 6 Interview immediately following the above observation with LPN F revealed that had been her normal procedure. Interview on 6/16/21 at 11:55 a.m. with administrator A concerning the above observation related to LPN F's hand hygiene and gastric tube placement revealed her expectation was: *Hand hygiene was completed when entering and leaving the resident's room and after removing and replacing gloves. *To ensure gastric tube placement prior to a feeding or administration of any medications. Review of the Quarter 3, 2018 Handwashing/Hand Hygiene Policy revealed: *"7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations:" -"b. Before and after direct contact with residents;" -"c. Before preparing or handling medications;" -"d. Before performing any non-surgical invasive procedures;" -"e. Before and after handling an invasive device (e.g., urinary catheters, IV access sites);" -"g. Before handling clean or soiled dressings, gauze pads, etc.;" -"h. Before moving from a contaminated body site to a clean body site during resident care;" -"i. After contact with a residents intact skin;" -"m. After removing gloves." Review of the 2018 Competency Assessment Enteral Feedings-Safety Precautions revealed: *"Preventing aspiration -1. Check enteral tube placement prior to each feeding and administration of medication."	F 658	Continued from Page 6 DON or Designee will educate licensed nurses, to include LPN F, on the facility's Enteral Feedings-Safety Precautions Competency, Charting and Documentation Policy and Care Plans, Comprehensive Person Centered Policy. Education will include: -Ensuring proper gastric tube placement prior to feeding or administration of medications. -Ensuring residents wound cleanser is not shared and assigned to one resident only, and discarded when expired. -Best practices for expiration documentation format of month/year. -Ensuring treatment of skin concerns are documented with family notification -Ensuring accurate documentation of skin concerns in medical record -Ensuring care plans are updated to reflect pressure ulcer development and resolution. DON or Designee will educate staff, to include LPN F, on the facility's Hand Washing/Hand Hygiene Policy. Education will include -Performing hand hygiene upon entering and leaving residents room and before donning gloves and after doffing gloves. -Before and after direct contact with residents -Before preparing or handling medications -Before touching medical equipment after glove use -Before touching personal clothing -Before performing any non-surgical invasive procedures -Before and after handling an invasive device (gastric tube) -Before handling clean or soiled dressings, gauze pads, scissors, etc	

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F 658	Continued From page 7 2. Observation on 6/16/21 at 10:45 a.m. of LPN F while performing a wound treatment on resident 23's right elbow revealed: *Resident 23 was sitting in a wheelchair next to the nurses station. -He had been brought to that area by activities aide G who had stated he received a skin tear while taking a bath. *LPN F performed hand hygiene and placed on gloves. *She used a sponge to dab the right elbow area of the resident. *With those same gloves she: *She opened the drawer of the treatment cart and retrieved a bottle of wound cleanser spray. -That wound cleanser spray bottle had writing near the top of the bottle consisting of an expiration date of 1/22 and a name of a resident who was not resident 23. -She used that wound cleanser on resident 23's elbow. *With those same gloved hands she: -Put her right hand into her smock pocket and retrieved her scissors. -Cut a steri-strip and placed it onto the residents elbow. *She removed her gloves and without performing hand hygiene she: -Picked up the scissors and cut a piece of adhesive and placed it onto the residents elbow. *When questioned she stated that had been her usual way of performing wound care. *When questioned about the bottle of wound cleanser she stated: -"Someone put [resident] name on it. -He wanted his name on it." -She then opened up an alcohol wipe and wiped the wound cleanser bottle till she removed the	F 658	Continued from Page 7 -Before moving from a contaminated body site to a clean body site during resident care -After contact with resident's intact skin LPN F will complete CMS targeted Covid 19 Training for Frontline Nursing Home Staff before 7/11/2021 or during next shift worked after. All current staff who have not completed CMS training, will be offered to complete CMS targeted Covid 19 Training for Frontline Nursing Home Staff. Education will be completed no later than 7/11/2021.Those who have not been educated by 7/11/2021 will be educated prior to their first shift worked after. Monitoring/QAPI DON or Designee will monitor residents with gastric tubes to ensure checking placement gastric tube prior to feeding or administration of medications, to ensure treatment supplies are not shared between residents, to ensure skin concerns are documented in medical record with treatment and family notification if required, to ensure care plans are updated with skin concerns to include pressure ulcer development and resolution. 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. Any concerns identified will be corrected immediately.	

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F 658	Continued From page 8 1/22 date and the residents name. -She stated "It's probably been open for four or five months and should be thrown away." *She threw the wound cleanser bottle into the trash can and walked into the clean storage area and the medication storage room looking for a new bottle of wound cleanser. *She came out of the medication storage room and came to me to inform me no one should have put [resident] name on the bottle of wound cleanser because it wasn't his. *When questioned why she used a cleanser with someone's name on it for a different resident she stated because it wasn't [name] his. Review on 6/17/21 at 9:45 a.m. of resident 23's progress notes and treatment record revealed no documentation of the above wound treatment had been documented on 6/16/21 after the treatment had been completed. Interview on 6/16/21 at 11:15 a.m. with administrator A regarding the above observation revealed: *Her expectation was gloves would have been removed and hand hygiene performed: -After cleaning the wound and touching the treatment cart. -Before putting her hand into her smock pocket. *Information written on the wound cleanser bottle should not have been removed and only used for the resident who's name had been on the bottle. Interview on 6/17/21 at 10:25 a.m. with administrator A regarding the lack of documentation by LPN F related to wound treatment revealed: *LPN F should have documented the wound care to resident 23's elbow immediately or as soon as	F 658	Continued from Page 8 Administrator/DON or Designee will monitor staff, to include randomly monitoring LPN F, to ensure appropriate hand washing/hand hygiene practices are being followed and will randomly include: staff understanding expiration documentation of month/year; to ensure hand hygiene is performed per policy to include entering and leaving a residents room, donning and doffing gloves, before and after direct contact with residents, before preparing or handling medications, before touching medical equipment after glove use, before or after touching personal clothing, before performing any non-surgical invasive procedure, before and after handling an invasive device (gastric tube), before handling clean or soiled dressings, gauze pads, scissors, etc, before moving from a contaminated body site to a clean body site during resident care, and after contact with resident's intact skin. 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 9 possible after completing the treatment. Review of the Quarter 3, 2018 Charting and Documentation Policy revealed: *"2. The following information is to be documented in the resident medical record:" -"c. Treatments or services performed." *"7. Documentation of procedures and treatments should include care-specific details, including:" -"a. The date and time the procedure/treatment was provided;" -"d. How the resident tolerated the procedure/treatment;" -"f. Notification of family, physician or other staff, if indicated; and" -"g. The signature and title of the individual documenting." 3. Observation and interview on 6/16/21 at 8:10 a.m. with resident 18 revealed: *He wore glasses and a surgical mask. *There was a Band-Aid beside his left ear on his scalp. *He stated that Band-Aid covered a sore caused by the surgical mask he wore. Review of resident 18's care record revealed a pressure injury had developed beside his left ear on 5/4/21 that healed on 5/26/21 and re-developed on 6/15/21. Review of resident 18's care plan last revised on 6/7/21 revealed no mention of a history of a pressure injury beside his left ear or the re-development of that same pressure injury. Interview on 6/17/21 at 1:00 p.m. with director of nursing B regarding resident 18's pressure injury revealed:	F 658		

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F 658	Continued From page 10 *She confirmed it was initially identified on 5/4/21 and caused by his surgical mask. -A different type of mask had been provided and that pressure injury resolved on 5/26/21. *She had thought that pressure injury re-occurred on 6/15/21 after the Band-Aid that covered the sore had been removed. -She was investigating another type of surgical mask that extended the length of the straps and fit the resident differently. *She confirmed the first and subsequent pressure injuries should have been documented on resident 18's care plan. -The nurse who had initially identified those pressure injuries on 5/4/21 and on 6/15/21 was responsible for revising resident 18's care plan. Review of the Quarter 3, 2018 Care plans, Comprehensive Person-Centered policy revealed: *"8. The comprehensive, person-centered care plan will:" -"g. Incorporate identified problem areas; -h. Incorporate risk factors associated with identified problems." -"m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels;" *"14. The Interdisciplinary Team must review and update the care plan: -a. When there has been a significant change in the resident's condition;".	F 658		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755	Corrective Action DON verified all controlled substances were accounted for.	7/11/2021

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F 755	Continued From page 11 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on interview, record review, and policy review the provider failed to ensure all controlled medications had been accounted for at shift changes for two of two medication carts. Findings include: Review of the 300 hall Controlled Substance Inventory Sheet revealed:	F 755	Identification of Others The facility has no other Controlled Substance Inventory Sheets in use at time of Plan of Correction. Systemic Changes: Administrator, DON, IDT and Medical Director reviewed and updated the facility's Controlled Substance Policy. DON or Designee will educate licensed nurses and medication aides on the Controlled Substance Policy and accurate accounting and use of new Controlled Substance Inventory Sheet. Education will be completed no later than 7/11/2021. Those who have not been educated by 7/11/2021 will be educated prior to their first shift worked after. Monitoring/QAPI: DON or Designee will monitor Controlled Substance Inventory Sheets, to include all medication carts, to ensure medications are accounted for with two (2) signatures for each shift change. 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. Any concerns identified will be corrected immediately. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed.	

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F 755	Continued From page 12 *Between 4/13/21 and 6/16/21 there were 14 signature lines that had been left blank. -That indicated not all controlled narcotics had been accounted for by two nurses after every shift. Review of the 400 hall Controlled Substance Inventory Sheet revealed: *Between 4/13/21 and 6/16/21 there were 38 signature lines that had been left blank. -That indicated not all controlled narcotics had been accounted for by two nurses after every shift. Interview on 6/17/21 at 12:15 p.m. with licensed practical nurses (LPN) C and E revealed they both agreed the Controlled Substance Inventory Sheet should have two signatures for each shift. Interview on 6/17/21 at 4:00 p.m. with administrator A and DON B regarding the controlled medication counts revealed: *They agreed there were missing signatures between 4/13/21 and 6/16/21 on hall 300 and 400's Controlled Substance Inventory Sheets. -DON B thought that had been the wrong sheet and there were other sheets that had been filled out completely. --She had been unable to produce those completed sheets. *Their expectation would have been that the narcotic count would have been completed after each shift by two employees. *Both agreed their facility policy had not been followed. Review of the providers Quarter 3, 2018 Controlled Substance Policy revealed: *"9. Nursing staff must count controlled	F 755		

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F 755	Continued From page 13 medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the DON." Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 755		
F 842 SS=D		F 842	Corrective Action: A Hospice notebook has been provided for Resident 4. Resident 31 expired 7/7/2021. Resident 26 expired 7/4/2021. Identification of Others DON/Designee validated no other residents receive Hospice Services in facility at time of Plan of Correction. Systemic Changes Administrator, DON, IDT and Medical Director reviewed and approved the facility's Hospice Program Policy. Administrator provided DON with hospice supervisor contact information for communication and coordination as the designated point of contact between facility and Hospice agency. Administrator will provide education to Director of Nursing on the Hospice Program Policy to include education of the DON being designated as the point of contact between Facility and Hospice agency.	7/11/2021

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F 842	Continued From page 14 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on interview, record review, and policy review, the provider failed to have a system in place for obtaining necessary documentation to ensure complete and accurate resident medical	F 842	continued from page 14 Facility will provide Hospice with a log in to Facility's EMR to allow Hospice staff to document a note about their visit with the resident. Hospice will provide Administrator and DON with meeting time for facility to provide education to hospice nurses on documentation into the Electronic Medical Record. Hospice nurses will document their name and a visit summary with communication of any follow up or suggestions relayed to facility nurses. Applicable hospice staff will provide a visit summary note as needed documented in the Hospice binders. DON or Designee will provide education to licensed nurses to ensure they are corresponding with Hospice staff and receiving resident specific hospice information during the shift and adding residents to observations if a change is noted, and to ensure that resident specific hospice information received is communicated through shift report and added to written 24 hour shift report. Education will include updating nurses of the systemic changes for hospice nurses to document visit notes in facility electronic medical record. Education will be completed no later than 7/11/2021. Those who have not been educated by 7/11/2021 will be educated prior to their first shift worked after.	

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F 842	Continued From page 15 records for three of three sampled residents (4, 26, and 31) who received hospice services through one of one hospice agency. Findings include: Review of residents 4, 26, and 31s' care plans revealed: *Resident 4 was admitted to hospice service on 5/14/21. *Resident 26 was admitted to hospice service on 5/25/21. *Resident 31 was admitted to hospice service on 5/24/21. Review on 6/15/21 at 4:00 p.m. of individual hospice agency notebooks for residents 4, 26, and 31 revealed: *Residents 26 and 31 had their own hospice agency notebooks at the nurses' station. -There was no notebook for resident 4. *Those notebooks contained completed and signed hospice agency admission paperwork. *Behind the nurse, social worker, chaplain, volunteer, and home health aide tabs were individual progress notes. -There was no completed documentation by any of these disciplines in either notebook. Interview on 6/15/21 at 4:30 p.m. and on 6/16/21 at 11:22 a.m. with licensed practical nurse (LPN) E regarding hospice agency documentation revealed she; *Had thought the provider kept hospice agency documentation in residents 4, 26, and 31 care records. -Was unable to locate any hospice agency documentation in those care records. *Confirmed the hospice agency had not entered documentation on the individual progress notes in	F 842	continued from page 15 Monitoring/QAPI: DON or Designee will monitor facility nurses to ensure resident specific hospice information is being added to the 24 hour shift report and communicated through shift report. Monitoring will be conducted weekly through chart review, observation and 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. DON or Designee will monitor Hospice Binders to ensure all disciplines are completing visit summaries at time of visit. Monitoring will be conducted weekly through chart review, observation and 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. DON or Designee will monitor progress notes to ensure Hospice Nurses are completing visit progress notes that include the nurses name, license, visit summary and what specific hospice information was given to facility nurse. Monitoring will be conducted weekly through chart review, observation and 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 Quality Assurance Committee monthly and as needed.	

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F 842	Continued From page 16 their hospice agency notebooks. *Had thought hospice agency documentation was entered in the agency's electronic medical record (EMR) system. -The hospice agency had no access to the facility EMR and the facility had no access to the hospice EMR. *Received resident specific hospice information verbally from hospice staff if she had worked on the day of that hospice visit. *Expected to receive resident specific hospice information during the shift change report if she had not worked on the day of a hospice visit. Interview on 6/16/21 at 5:20 p.m. with director of nursing B regarding communication between the provider and the hospice agency regarding hospice service revealed she: *Had thought hospice agency staff documented visit summaries on the interdisciplinary progress notes kept in the individual hospice notebooks kept at the nurses' station. *Knew agency staff used an EMR charting system for complete hospice documentation that the provider did not have access to. -Stated copies of hospice documentation from that EMR for residents 4, 26, and 31 had been received by the provider on 6/9/21 but had not been filed in the provider's care records for those residents. -The Minimum Data Set (MDS) nurse had it in her possession. *Agreed care records for residents 4, 26, and 31 had not included complete and accessible hospice information for those residents. -It was her expectation that the care record had reflected ongoing information exchanges between the agency and provider in order to respond to the changing status and needs of those hospice	F 842		

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F 842	Continued From page 17 residents. Review of the "Qtr. [quarter] 3, 2018" Hospice Program policy revealed: *"12. Our facility has designated Director of Nursing/designee to coordinate care provided to the resident by our facility staff and the hospice staff. He or she is responsible for the following:" -"b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family."	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.	F 849	Corrective Action: Resident 31 expired 7/7/2021. Resident 26 expired 7/4/2021. Resident 4's care plan was updated to reflect what hospice services will be provided, how often hospice services are to be provided in the facility and how hospice care is used. Identification of Others DON/Designee validated no other residents receive Hospice Services in facility at time of Plan of Correction. Systemic Changes: Administrator, DON, IDT and Medical Director reviewed and approved facility's Hospice Program Policy.	7/11/2021

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F 849	Continued From page 18 (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112.(d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.	F 849	continued from page 18 Administrator will provide education to IDT to ensure hospice resident's care plans are updated and include what hospice services will be provided, how often hospice services are to be provided in the facility and how hospice care is used and to include facility collaborating with Hospice ensure care planning is integrated with facility for residents receiving Hospice services to maintain the highest practicable physical, mental and psychosocial well-being. Education will be completed no later than 7/11/2021.Those who have not been educated by 7/11/2021 will be educated prior to their first shift worked after. Monitoring/QAPI Administrator or Designee will monitor hospice resident care plans to ensure facility is collaborating with Hospice agency and care plans are updated with most recent plan of care, the services provided by Hospice, how often services are provided in the facility and how hospice care is used. Monitoring will be conducted weekly through chart review, observation and 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 Quality Assurance Committee monthly and as needed.	

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F 849	Continued From page 19 (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The	F 849		

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F 849	Continued From page 20 interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if	F 849		

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F 849	Continued From page 21 any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on interview, record review, and policy review, the provider failed to ensure integrated plans of care had been developed for three of three residents (4, 26, and 31) receiving hospice services. Findings include: Review of residents 4, 26, and 31s' care plans revealed: *Resident 4 had no hospice care plan. *Resident 26's hospice care plan was initiated at the time of her hospice admission on 5/25/21. *It included an intervention: "See Hospice plan of care for additional goals/interventions." -There was no hospice plan of care to refer to. *No interventions had identified what hospice services were provided, how often hospice services were to have been in the facility, or how hospice care was used. *Resident 31's hospice care plan was initiated at the time of her hospice admission on 5/24/21. -It included an intervention: "Care coordination	F 849		

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	435035	A. BUILDING _____ B. WING _____	C 06/17/2021

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F 849	Continued From page 22 with (the name of) home health hospice, staff to communicate and facilitate any needs through coordination with hospice staff. Facility staff to support family through this process." *No interventions had identified what hospice services were provided, how often hospice services were to have been in the facility, or how hospice care was used. Interview on 6/16/21 at 5:20 p.m. with administrator A and director of nursing (DON) B regarding hospice care plans revealed: *DON B confirmed she had been designated as the point of contact between the provider and the hospice agency. -She had not identified a point of contact at the hospice agency to establish a working relationship with regarding those residents who received hospice care. *Confirmed copies of hospice care plans for residents 4, 26, and 31 had been received from the hospice agency on 6/9/21 but had not been filed in their care records. *DON B and administrator A confirmed hospice residents' plans of care had not been developed in coordination with the hospice agency but should have been. Review of the "Qtr. [quarter] 3, 2018" Hospice Program policy revealed: *"12. Our facility has designated Director of Nursing/designee to coordinate care provided to the resident by our facility staff and the hospice staff. He or she is responsible for the following:" -"a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services;" *"13. Coordinated care plans for residents	F 849		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 849	Continued From page 23 receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility including the responsible provider and discipline assigned to specific tasks' in order to maintain the resident's highest practicable physical, mental and psychosocial well-being."	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880	Directed Plan of Correction Refer to F658 for initial POC Corrective Action Administrator, DON and Infection Control nurse discussed identified areas cited via phone call on 7/6/2021 with RN, CDP, CADDCT, Quality Improvement Advisor, Great Plains Quality Innovation Network. Education provided during call included refraining from sharing wound cleanser, monitoring all staff for adherence to hand hygiene for all cares and treatments across all shifts and departments. Administrator, DON, IDT and Medical Director reviewed and approved facility's Hand washing/Hand Hygiene Policy. Identification of Others: All residents have the potential to be at risk if staff do not adhere to appropriate hand hygiene and appropriate maintenance and disposal of wound cleanser spray. All Staff completing the care and/or assigned tasks have the potential to be affected.	7/11/2021

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	435035	A. BUILDING _____ B. WING _____	C 06/17/2021

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F 880	Continued From page 24 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on observation, interview, and policy	F 880	continued from page 24 Systemic Changes: Administrator, DON and Infection Control reviewed Infection Control Policies and individual roles and responsibilities for infection control. All policies and roles were approved. A Root Cause Analysis (RCA) was conducted. RCA determined some staff are not attending all staff meetings on a regular basis missing out on vital discussions with face-to-face dialogue and demonstrations, with further questions asked and answered with discussions during the meetings. Staff are getting written documentation with the all staff meeting education but the verbal discussions during these meetings would have prevented the areas of concern leading to the identified infection control citations. Administrator, DON, Infection Control contacted and completed a video call with an RN, CDP, CADDCT, Quality Improvement Advisor, from Great Plains Quality Innovation Network on 7/6/2021 and discussed the RCA completed by facility. The RCA was described as an exceptional RCA with thorough documentation that drilled down to an appropriate root cause for the citations. Further discussion included audit tracking tools and education from CMS for frontline staff and refraining from sharing wound cleanser as referred in F658 POC. Discussion also included continued plans to address RCA. These plans include ensuring staff who are not attending all staff meetings are given verbal and written education with opportunities for questions and answers.	

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	435035	A. BUILDING _____ B. WING _____	C 06/17/2021

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F 880	Continued From page 25 review, the provider failed to ensure appropriate hand hygiene by one of one licensed practical nurse for: *One of one sampled resident (37) with a gastric tube during enteral feeding and medication administration. *One of one resident (23) during wound treatment for a skin tear to his right elbow. Findings include: 1. Observation on 6/15/21 from 12:30 p.m. through 1:30 p.m. and 6/16/21 from 10:45 a.m. through 11:15 a.m. revealed the provider failed to ensure: *Proper hand hygiene and glove use by one of one licensed practical nurse (F) during enteral feeding/administration of medications and during wound treatment. *A wound treatment spray was only used for the resident who's name was on the bottle. 1. a. Refer to F658, Finding 1 and 2.	F 880	Also discussed is the facility will initiate all staff meeting recordings and invite staff not able to attend meetings to join via video/ phone conference. The RCA was discussed and approved by the IDT and Medical Director. Monitoring: Refer to F658 for additional monitoring. Administrator or designee will monitor human resources for timely reporting to department managers of staff missing all staff meetings. Monitoring will be conducted monthly through chart review, observation and interviews until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 3 months. Any concerns identified will be corrected immediately. Administrator or designee will monitor department managers to ensure managers are providing staff with written and verbal education and/or viewing video recording of all staff meeting and/or joined all staff meeting video/phone conference. Administrator or designee will monitor staff, to include LPN F, for participation in watching meeting videos and if they are joining from phone, home or computer to ensure staff knowledge of education is received in the same as staff attending all staff meeting face-to-face. Monitoring will be conducted monthly through chart review, observation and interviews until a lessor frequency is deemed appropriate by the QAPI committee for a minimum of 3 months. Any concerns identified will be corrected immediately. Administrator or designee will report any identified trends to Quality Assurance Committee monthly and as needed.	

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	435035	A. BUILDING _____ B. WING _____	06/15/2021

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E 000	Initial Comments Surveyor: 18087 A recertification survey for compliance with 42 CFR Part 482, Subpart B; Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted on 6/15/21. Rolling Hills Healthcare was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: T Harwood
TITLE: Administrator
(X6) DATE: 7/9/2021

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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	435035	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/15/2021

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/15/21. Rolling Hills Healthcare was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thawood
TITLE: Administrator
(X6) DATE: 7/9/2021

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

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	10594	A. BUILDING: _____ B. WING _____	06/17/2021

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S 000	Compliance/Noncompliance Statement Surveyor: 40053 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/15/21 through 6/17/21. Rolling Hills Health Care was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 40053. 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 6/15/21 through 6/17/21. Rolling Hills Health Care was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: THarwood — TITLE: Administrator — (X6) DATE: 7/9/2021