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	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Healthcare	2200 13th Ave Belle Fourche, SD 57717

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43844 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, observation, and policy review, the provider failed to ensure the safety of one of one sampled resident (2) who had fallen from a tub chair when the lap belt (a belt to secure the resident into the chair) was not appropriately placed. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 5/15/24 SD DOH FRI revealed: *On 5/15/24 at 5:30 a.m. resident 2 fell out of the tub chair. -The lap belt that was to be used to secure a resident into the tub chair had not been placed around resident 2. -The resident was assessed at the facility and found to have no apparent injuries. -The facility received physician orders to transfer her to the emergency room (ER) for X-rays. -The X-ray results were negative for bone fractures. -ER evaluation identified she had low blood pressure. The provider implemented systemic changes to ensure the deficient practice does not recur was confirmed after: record review revealed the facility had followed its quality assurance process, education was provided and competencies were provided to all staff who provided bathing assistance to residents, a secondary belt, for the chest area, was purchased and put into place on the tub chair, audits were being completed that verified the safe use of the tub chair and the securing of lap and chest belts. Based on the above information, non-compliance at F600 occurred on 5/15/24 and based on the provider's implemented corrective actions for the deficient practice confirmed on 6/27/24, the non-compliance is considered past non-compliance.

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.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 43844 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, observation, and policy review, the provider failed to ensure accurate assessment for the elopement risk for one of one sampled resident (1) who eloped (left the facility without staff knowledge) when he entered the code to turn off the alarms on the door to the enclosed patio and courtyard, exited that enclosed courtyard, and walked approximately two blocks from the facility before he was found. Findings include: 1. Review of the provider's 6/24/24 (DATE) SD DOH FRI revealed: *On 6/24/24 at 5:05 a.m. resident 1's walker was found by the courtyard door. -At 5:27 a.m. resident 1 was found in walking in a field. -He was returned to the facility, assessed, and was found with no injuries. Review of resident 1's medical record revealed: *His 5/28/24 SLUMS (a brief screening test for detecting mild cognitive impairment and dementia) score was a 14 out of 30, which indicated he may have dementia. *His 3/20/24 Brief Interview of Mental Status score was a 15, which indicated his cognition was intact. *His 6/14/24 Elopement Risk Assessment revealed he had no wandering behaviors and was at low risk for elopement. Review of resident 1's 6/27/24 care plan indicated: *A 6/12/24 focus area that included: -He had a diagnosis of dementia with agitation and anxiety. -He wandered outside, into other resident's rooms, hallways, and urinated outside. *Interventions for that focus area included staff were: -To educate him when his behavior included going in and out of other resident rooms, was exit seeking and setting off alarms. -To provide a 1:1 (one to one) visits when he is displaying depressive moods or feeling down, when highly agitated, exit seeking, angry or aggressive. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-To escort him outside, provide constant encouragement, and redirection. *A 6/24/24 focus area that indicated he was an elopement risk due to a successful elopement. -He had made statements of wanting to leave, intending to leave, and he had sufficient mobility to exit unescorted. -Staff were to notify his physician of any elopements and to follow the provider's elopement policy. *Additional individualized interventions included staff were to: --Observe him for his knowledge of alarm codes and notify administrator [ADM] A if resident knows codes. Provide constant supervision with 1:1 supervision when he is stated he planned to leave facility. -Offer him to take walks through the courtyard with staff throughout the day. Review of resident 1's progress notes revealed: *On 5/11/24 a nurse's note that included: -On 5/10/24 at 19:15 (7:15 p.m.) an unidentified certified nurse aide (CNA) had seen resident 1 walking along the street -At that time she [CNA] was sitting with the wife, who was in their vehicle. Resident had at some point gotten out of the vehicle and refused to get back in because he refused to come back to the facility. -At 19:45 (7:45 p.m.) the cop showed up at the facility with resident. -Resident (1) agreed to come into facility, but stated that he intended to leave as soon as staff turned their back. -Frequent checks have been made on resident. *A 6/5/24 certified nurse practitioner note (CNP) that indicated: He had intermittent periods of confusion. -Has had some desire to exit building, enjoys spending time in the sun. Elopement in past. *A 6/8/2024 nurse's behavior note that noted, Resident will not remain in the facility and he has now been going outside to urinate. Resident will not listen to staff redirection. Resident refuses any and all behavior interventions suggested by staff. Cont. [continue] to attempt and monitor. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A follow-up note to that behavior note that indicated Staff have tried: distraction, redirection, wii [Wii] games, 1:1, encouraging resident to relax in recliner with feet up, reading a book, conversing with staff, family phone calls. Resident will not accept any interventions and is noncompliant with education given regarding peeing outside and or wandering. *A 6/9/24 note to redirect him from doors, and to walk with him when he is wandering. -He was not easily redirected. -He did allow staff to escort him outside to the patio. -He was worked up and anxious, he has been wandering all shift. Interview on 6/27/24 at 2:34 p.m. with CNA E regarding resident 1 revealed: *Resident 1 often went outside to the courtyard and staff would assist him back in. -There were two doors he would go out, one by the dining room and the other at the end of the hall where he resided. Interview on 6/27/24 at 2:44 p.m. with licensed practical nurse C regarding resident 1 revealed: *She thought he was at risk for elopement. -Staff were monitoring him as he often went towards the courtyard doors. *Elopement assessments were completed by a nurse when a resident was admitted for care. -She thought other assessments were done on a quarterly basis. Interview on 6/27/24 at 2:55 p.m. with CNA G regarding resident 1 revealed: *On 6/24/24 at 5:00 she arrived at work. -She heard a code pink announcement, which meant a resident was missing. -The code was to search for resident 1. *Resident 1 often wandered, and had a history, prior to 6/24/24, of going outside and not telling anyone. *Resident 1 wore a call light pendant, and staff were to make sure he had it on. -The call light pendant had been found in his trash can several times. Interview on 6/27/24 at 3:09 p.m. with director of rehabilitation/speech therapist F regarding resident 1 revealed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Resident 1 had an elopement on 6/24/24. *He had slipped through the courtyard and crossed the field. *He was exit seeking prior to that incident and he was normally easy to re-orientate. *She stated, The fact that he was previously exit seeking and at home with [the] same behavior I believe is relevant to this specific investigation. Interview on 6/27/24 at 3:30 p.m. with ADM A and director of nursing (DON) B regarding resident 1 revealed: *ADM A said on 5/11/24 resident 1 had gone on an outing with his wife. -He had walked away from her, knowing that she would follow him. -She thought his wife had eyes on him at all times, therefore they had not considered it an elopement. -He had told ADM A I just wanted to walk. *DON B thought the 6/5/24 CNP statement documented in resident 1's medical record was a misstatement. -They had stated that he had not eloped from the facility prior to 6/24/24 and was not at risk for elopement then. *ADM A stated they had determined the root cause for his elopement was that he was angry at his wife for dropping him off [at the facility]. Interview on 6/27/24 at 3:54 p.m. with resident 1's spouse revealed: *About a month ago he had walked away from her at the store. -He walked several blocks. -The police had to come pick him up and return him to the provider's facility. *This was the first time that had happened. Continued interview on 6/27/24 at 4:02 p.m. with ADM A and DON B regarding the accuracy of resident 1's assessments revealed: *DON B indicated when a resident is admitted they have a safety care plan developed. -They had been monitoring resident 1 for safety since his admission. *ADM A stated he had made it outdoors to the courtyard by himself just the last few weeks. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He liked to walk through the courtyard. *They both stated they thought his 6/14/24 Elopement Risk Assessment had been coded correctly. Review of the provider's 3/2019 Wandering and Elopements policy revealed, The facility will identify residents who are at risk for unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Review of the provider's 3/2022 Resident Assessments policy revealed, All members of the care team, including licensed and unlicensed staff members, are asked to participate in the resident assessment process.