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	01/28/2025

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47780 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, record review, interview, and personnel file review, the provider failed to protect the resident's right to be free from physical abuse by one of one registered nurse (RN) (B) while providing evening cares for one of one sampled resident (1). This citation is considered past non-compliance based on a review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 1/15/25 SD DOH FRI revealed the provider had determined physical abuse had occurred when RN B slapped resident 1 while providing evening cares on 1/14/25. Observation on 1/28/25 at 10:00 a.m. in resident 1's room revealed: *She was sleeping in her recliner with a blanket over her lap. *A gray call light was on the bedside table to her right. *She had a fall mat on the floor next to her bed. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on [DATE] and her diagnoses included hemiplegia and hemiparesis (partial paralysis) following nontraumatic subarachnoid hemorrhage (bleeding between the brain and tissue covering the brain) affecting left non-dominate side, dementia, restlessness, agitation, anxiety, and dysphasia (condition that affects understanding and speech). *Her Brief Interview for Mental Status (BIMS) assessment score was an 8 which indicated she had moderate cognitive impairment. *Two skin assessments were completed as follows: -On 1/15/25 at 12:04 a.m. Bruising to R [right] side of forehead from previous fall, R [right] side of face and cheek-redness, R [right] skin tear has reopened-are cleansed and redressed (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	-On 1/15/25 at 3:30 a.m. one red scratch mark-unopen, cleanse left open to air, three scratch marks that are re, superficial unopen, cleansed and left open to air, bruising to R [right] side of forehead from prior fall, skin tear to R [right] forearm-dressed *The resident's care plan was updated on 1/15/25 to reflect staff were to: -Monitor for increase/changes in mental anguish, fear, intimidation, and address accordingly. Changes in skin or pain. Notify POA [Power of Attorney], MD [Medical Director], LNHA [Licensed Nursing Home Administrator]. -Encourage to participate in activities outside of room, including meals and other social activities. -1:1 (one-to-one) validation of feelings and concerns, as needed. *The provider had multiple progress notes entered that showed her behavior was pleasant toward staff, they had not noticed any new behaviors since that incident had occurred *On 1/22/25 the facility entered and IDT (interdisciplinary team) note as follows: -*[Resident 1] has not displayed fear, intimidation, changes in mood, changes in daily routine, activities, meals, or interactions with staff and residents. [Resident 1] has been her normal self, and had not mentioned the incident. -*[Resident 1] has no changes with activities, she enjoyed pet visit per normal, joined art projects observations and people watching, enjoyed seeing the projects other residents completed, socializing with residents during other activities, no fear or intimidation, participating per her normal activity. -*Social Services has visited with [Resident 1] on numerous days since incident. [Resident 1] has no changes in mood, has not recalled the incident. She has had no changes in daily routine, does not show fear or intimidation. Has been enjoying increased visits. Interview on 1/28/25 at 1:06 p.m. with certified nursing assistant (CNA) C regarding the incident involving resident 1 and RN B revealed: *She stated resident 1 did not want to go to bed, and RN B had been forcing her. -CNA C stated RN B told her a skin assessment needed to be completed. *She felt uncomfortable with what RN B was doing and tried to leave, but RN B told her she had to stay. *RN B had been forceful with her handling of the resident, the resident hit her and RN B then slapped resident 1's face. *After RN B slapped resident 1, CNA C and CNA D told RN B she needed to leave and that they would finish getting resident 1 ready for bed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	*CNA C stated RN B pulled her aside later and told her what happened had been her fault, CNA C should not snitch on her and RN B would call the administrator. *CNA C had worked with resident 1 since the incident and resident 1 had not shown any new behaviors or fear when she had assisted resident 1 for bedtime. Interview on 1/28/25 at 1:31 p.m. with CNA D regarding the incident involving resident 1 and RN B revealed: *She came in at 9:00 p.m. for her shift to relieve CNA C, and she could tell RN B was agitated when she arrived. *She stated RN B told both the CNA that resident 1 wanted to lie down, but CNA D stated that resident 1 did not want to lie down. *When resident 1 refused to lie down, RN B seemed upset and pushed her backward in her wheelchair, transferred her onto her bed, and started taking resident 1's clothes off of her. *She confirmed CNA C tried to leave but RN B would not let her. *Resident 1 was getting upset and was hitting and slapping RN B. *After RN B slapped resident 1 she said CNA C and herself told RN B to leave and they would get resident 1 ready for bed. *She stated RN B pulled her aside and told her not to snitch on her and that she would tell the administrator. *CNA D had worked with resident 1 since the incident and resident 1 had not shown any new behaviors or fear when she assisted resident 1 for bedtime. Review of RN B's personnel files revealed: *Her professional certification or licenses were current, and her pre-employment background checks identified no areas of concern. *Her mandatory resident rights and abuse/neglect training's were current. *She was terminated on 1/15/25. Interview on 1/28/25 at 2:00 p.m. with LNHA A revealed: *The incident was reported to the South Dakota Board of Nursing. *The incident was reported to the local law enforcement. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	*All residents were interviewed and the residents that were not able to be interviewed, had orders in their charts to monitor for psychological changes, signs and symptoms of mental anguish, fear, intimidation, behavioral changes, oral intake, withdrawal, isolation, sleep changes/nightmares, or depression. The provider's implemented systemic actions to ensure the deficient practice does not reoccur was confirmed on 1/28/25 after: *Education was provided to staff on abuse and neglect and how to deal with difficult residents. -Interviews with the two CNAs revealed they understand that education regarding those topics. *Handouts to all staff members regarding burnout including: -Reason for burnout. -What is burnout? -Preventing burnout. -Stages of burnout. -Symptoms of burnout. *Resident 1's care plan was revised to reflect any behavioral changes, and the interventions put into place for staff to notify the nurse. *Monthly nurse meetings included the topics of abuse and neglect. *All staff were interviewed and understood the education provided regarding expectations of abuse prevention including reporting, any observations of staff verbally, physically, or mentally abusing a resident. Based on the above information, non-compliance at F600 was determined on 1/14/25, and based on the provider's implemented corrective actions for the deficient practice confirmed on 1/28/25, the non-compliance is considered past non-compliance.