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	06/03/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation, job description review, and policy review, the provider failed to promote the resident's right to quality of life to ensure:*Seven of eighteen sampled residents (1, 2, 3, 4, 5, 6, and 7) received staff assistance to have been bathed no less than weekly and per their individual preference. *There was an accurate and consistent process for documenting resident baths in each resident's electronic medical record (EMR). Findings include: 1. Review of resident 2's electronic medical record (EMR) revealed:*She was admitted to the facility on [DATE]. * Her 5/13/25 Brief Interview for Mental Status (BIMS) assessment score was 11, which indicated she had a moderate cognitive impairment. *Her 5/10/25 care plan focus area and intervention for dressing/grooming/bathing indicated she required extensive assistance from one staff person with her bath. Review of resident 2's 5/5/25 through 6/3/25 bath book documentation and her EMR bathing documentation revealed:*Her baths were scheduled every Monday and Thursday on thelong-term care bath schedule a.m. lists. *There was no documentation that she had bathed from 5/12/25 through 5/22/25.*Scheduled baths that were not provided had not been rescheduled. *Resident 2 had not refused baths during that time.2. Review of resident 3's EMR revealed:*She was admitted to the facility on [DATE]. *Her 4/15/25 BIMS assessment score was 14, which indicated she was cognitively intact. *Her 5/26/25 care plan focus area and intervention for dressing/grooming/bathing indicated she required extensive assistance from one staff person with her bath. Review of resident 3's 5/5/25 through 6/3/25 bath book documentation and her EMR bathing documentation revealed:*The resident had been scheduled for one bath and was bathed on 5/14/25 during that period.*No other baths were scheduled or recorded in the EMR or on the bath sheets during that period. *Scheduled baths that were not provided had not been rescheduled. *Resident 3 had not refused baths during that time.Interview on 6/3/25 at 2:52 p.m. with resident 3 in her room revealed:*She stated she received one bath each week on Tuesdays. *She indicated she did not receive her scheduled Tuesday morning bath on 6/3/25.*Staff did not provide her with an explanation or reschedule the bath. *She expressed she preferred two baths a week and that she did not receive her baths consistently.3. Review of resident 4's EMR revealed: *She was admitted to the facility on [DATE]. *Her 4/15/25 BIMS assessment score was 9, which indicated she had a moderate cognitive impairment. *Her 4/25/25 care plan focus area and intervention for dressing/grooming/bathing indicated she required extensive assistance with her shower once a week. *She occasionally refused her showers. Review of resident 4's 5/5/25 through 6/3/25 bath book documentation and her EMR bathing documentation revealed:*Her shower was scheduled on the Saturday/Sunday long-term care bath schedule a.m. lists. *It was documented in her EMR and on the bath sheet that she refused her shower on 5/10/25.*There was no documentation that she had bathed after her refusal on 5/10/25 during that period. *Scheduled showers that were not provided had not been rescheduled. Interview on 6/3/25 at 3:05 p.m. with resident 4 in her room revealed:*She preferred a shower once a week during the daytime.*She was unable to recall if she received her shower from staff on a consistent basis.4. Review of resident 5's EMR revealed:*She was admitted to the facility on [DATE]. *Her 3/18/25 BIMS assessment score was 1, which indicated she had a severe cognitive impairment. *Her 3/15/25 are plan focus area and intervention for dressing/grooming/bathing indicated she required extensive assistance from one staff person with her bath. Review of resident 5's 5/5/25 through 6/3/25 bath book documentation and her EMR bathing documentation revealed:*Her bath was scheduled every Thursday on the long-term care bath schedule a.m. list. *She exhibited behaviors and refused bathing and other care occasionally. *There was no documentation that she had bathed from 5/8/25 through 5/22/25.*Scheduled baths that were not provided had not been rescheduled. 5. Review of resident 6's EMR revealed:*She was admitted to the facility on [DATE]. *Her 5/6/25 BIMS assessment score was 6, which indicated she had a severe cognitive impairment. *Her 5/6/25 care plan focus area and intervention for dressing/grooming/bathing indicated she required extensive assistance from one staff person with her bath. Review of resident 6's 5/5/25 through 6/3/25 bath book documentation and her EMR bathing documentation revealed:*Her bath was scheduled every Thursday and Sunday on the long-term care bath schedule p.m. list. *There was no documentation that she had bathed after 5/1/25.*Scheduled baths that were not provided had not been rescheduled. *Resident 6 had not refused baths during that time.6. Review of resident 7's EMR revealed: *She was admitted to the facility on [DATE]. *Her 6/3/25 BIMS assessment score was 8, which indicated she had moderate cognitive impairment. *Her 5/26/25 care plan focus area and intervention for