

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/29/2025
NAME OF PROVIDER OR SUPPLIER Rolling Hills Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Based on a South Dakota Department of Health (SD) (DOH) facility-reported incident (FRI) review, interview, record review, and policy review, the provider failed to ensure staff implemented interventions for one of one sampled resident (1) identified with risk for burns from hot liquids, who subsequently sustained a burn from hot coffee. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: Her admission date was 4/15/25. The resident's Hot Liquid Safety Evaluation with an effective date of 9/8/25 indicated she required a cup with a lid or other adaptive cup and a clothing protector and/or lap protector when she drank hot liquids. Resident 1's 9/8/25 revised care plan revealed: I am at risk for hot liquid spills, please ensure I use a cup with a lid and am sitting upright for all hot beverages. Her 9/10/25 Brief Interview for Mental Status (BIMS) assessment score was 14. That indicated she had no cognitive deficits. 2. Review of the provider's 9/10/25 FRI regarding resident 1 revealed: On 9/10/25, resident 1 had requested certified nurse aide (CNA) H to fill her personal Thermos cup with coffee. Neither the facility's bistro kitchen nor the primary kitchen had coffee available to serve. Cook E told CNA H there was coffee in the employee breakroom. He was not aware that CNA H would not have known to cool the breakroom coffee before she had poured it into resident 1's cup. The lid on the Thermos cup of coffee was tightened before CNA H handed the cup to resident 1. A short time later, resident 1 was heard calling out for help from her room. She stated that when the coffee in her cup reached her mouth, it was too hot. She expelled the coffee from her mouth onto her chest. Small blisters had formed on her upper chest where she had been burned. Resident 1 was not wearing a clothing protector at the time of the incident. The resident's medical provider was notified of the incident and ordered Lidocaine (a topical analgesic) to be applied to the resident's burn. The provider's post-incident interview with CNA H revealed she did not know there were temperature differences between the kitchen and bistro coffee and the breakroom coffee. Residents were not expected to be served coffee from the employee breakroom because the temperature of that coffee was not monitored. Through the provider's secure electronic messaging system, all staff were immediately reminded that residents were not to be served coffee from the employee breakroom. Additional staff education was provided during the provider's 9/12/25 Nursing Department Meeting. Hot beverage education was also added to the provider's new staff orientation checklist. Resident 1's care plan was updated after the above accident to include: any hot beverage served to resident 1 was expected to be served in a lidded cup. The use of her lidded Thermos remained appropriate. 3. Interview on 9/29/25 at 12:37 p.m. with cook E revealed resident 1 was currently using her lidded Thermos cup to drink coffee. If that cup was not available or if she preferred, her coffee was served in one of the kitchen's insulated coffee mugs. Those mugs had no fitted lids. Cook E stated that the kitchen did not maintain a list of residents who required specific accommodations, such as lids, when they were served hot beverages. 4. Interview on 9/29/25 at 1:35 p.m. with dietary manager D revealed that the kitchen had no coffee mugs with fitted lids for residents' use. 5. Interview on 9/29/25 at 2:00 with director of nursing (DON) B revealed that after resident 1's 9/10/25 burn, she had observed the resident between 9/11/25 and 9/16/25 to ensure her coffee was being served in a lidded mug. Those audits ended after 9/16/25. DON B had not seen resident 1 use anything other than her lidded Thermos cup to drink hot beverages. 6. Observation on 9/29/25 at 2:05 p.m. of resident 1 in her room with DON B and interview with resident 1 revealed the resident was lying in her bed. The resident's Thermos was not seen. Resident 1 did not know where her Thermos was or when she last saw it. Resident 1 stated that she sometimes used an unlidded coffee mug from the kitchen to drink her coffee from. Interview on 9/29/25 at 2:10 p.m. with DON B confirmed that neither the recommendations from resident 1's above Hot Liquid Safety Evaluation nor the intervention on her above care plan to ensure she used a cup with a lid for hot beverages were followed to mitigate resident 1's risk for burns from hot liquids. Review of the provider's Quarter 3, 2018 Safety of Hot Liquids policy revealed: 4. Once risk factors for injury from hot liquids are identified, appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include b. Serving hot beverages in a cup with a lid; Review of the providers' revised 5/16/25 Incidents and Accidents policy revealed: Policy Explanation: The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on a South Dakota Department of Health (SD) (DOH) facility-reported incident (FRI) review, record review, interview, job description review, and policy review, the provider failed to implement comprehensive trauma-informed care for one of one sampled resident (1) with post-traumatic stress disorder (PTSD-a disorder in which an individual has difficulty recovering after experiencing or witnessing a traumatic event). Findings include: 1. Review of the provider's 9/10/25 FRI revealed resident 1 had requested certified nurse aide (CNA) H to fill her Thermos cup with coffee. Shortly after filling and returning that cup to the resident, the resident was heard calling out for help from her room. She stated that when the coffee reached her mouth, it was hot, and she expelled the coffee from her mouth onto her chest, resulting in a hot liquid burn. When director of nursing (DON) B spoke with resident 1 after the incident, the resident became upset. She told DON B that, as a child, her mother had burned her. The facility was aware that resident 1 had experienced childhood abuse, but did not know she was intentionally burned by a family member. Resident 1 stated that the above burn incident had triggered her to have thoughts of harming herself. The resident's medical provider was updated, and resident 1 was transferred to a nearby hospital for evaluation related to those thoughts of self-harm.2. Review of resident 1's electronic medical record (EMR) revealed she was admitted to the nursing home from a hospital on 4/15/25. Before the hospitalization above, the resident was a participant in a community-based service agency that served individuals with developmental disabilities (conditions that begin in childhood and result in physical, learning, language, and/or behavior impairments that last a lifetime) (DD).Her 4/15/25 hospital discharge summary and physician's orders had included the following diagnoses: DD, anxiety, major depressive disorder, post-traumatic stress disorder (PTSD), and a seizure disorder.A psychiatrist's name was beside PTSD on the problem list in that same report.Her 9/10/25 Brief Interview for Mental Status (BIMS) score was 14, which indicated her cognition was intact.Resident 1's 4/16/25 Trauma Assessment score was zero. A trauma screen was considered positive for scores of 14 or greater. Her 6/21/25 Trauma Assessment score was eight. It included that the resident felt upset and was bothered a little bit when something reminded her of a stressful experience from the past. She also had avoided activities or situations a little bit because they had reminded her of a stressful experience from the past. A 6/16/25 psychiatry progress note indicated that resident 1 wanted to speak with a therapist like the one she had talked to regularly at the community-based DD program. That same note stated resident 1 had past psychiatric hospitalizations and suicidal thoughts at times, but had not acted on them and did not have a plan to act on them. A trauma-informed care plan was not initiated for resident 1 until after her 9/10/25 burn incident.A 9/16/25 Social Services Designee (SSD) progress note indicated that resident 1 was seen by a counseling service on that day and was given different exercises to perform when she was anxious.3. Interview on 9/29/25 at 3:00 p.m. with SSD G regarding resident 1's trauma-informed care revealed:She agreed that the above Trauma Assessments failed to identify the resident's trauma history, her developmental and functional history, her support network, or her strengths and coping mechanisms.SSD G stated that resident 1 had not shared much information with her regarding her trauma history. All SSD G had initially known about resident 1's PTSD was that the resident had experienced abuse by her parents in her childhood.SSD G agreed she should not have waited until resident 1's 9/10/25 burn incident to initiate resident 1's trauma-informed care plan. She felt, during the five months since the resident's admission, that the staff had gotten to know resident 1 better. Resident 1's individualized trauma information was appropriate to have included in a trauma-informed care plan and would have helped staff care for and interact with the resident to address her PTSD needs. SSD G confirmed she could have, but did not attempt to obtain psychiatric information regarding resident 1 from either the psychiatrist identified in the resident's 4/15/25 hospital discharge summary or the therapist referred to in the 6/16/25 psychiatry progress note.She did not request a copy of the resident's individual service plan that the DD agency had followed to manage the resident's PTSD and mental health concerns from resident 1's contact person, who was also the resident's caseworker at the DD program. SSD G had not followed up with the counselor referred to above, whom the resident 1 saw on 9/16/25, regarding the exercises the resident was encouraged to use when she was anxious. She agreed that those exercises may have been appropriate to have been carried over and implemented by the nursing home staff. SSD G felt that resident 1 would have no problem signing a release of information to allow SSD G to obtain records from the above individuals. Review of the provider's revised 6/16/25 Trauma Informed Care policy revealed:2 The facility will use a multi-pronged approach to identifying</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on a South Dakota Department of Health (SD) (DOH) facility-reported incident (FRI) review, summary of investigation review, record review, interview, and policy review, the provider failed to ensure a resident's medication needs were met, which included ensuring: A physician-ordered PRN (as needed) medication for the treatment of prolonged seizure activity was available for administration to one of one sampled resident (1). A physician-ordered PRN medication was accurately transcribed in one of one sampled resident's (1) electronic medical record (EMR). Findings include: 1. Review of the provider's 8/5/25 FRI revealed: On 8/4/25, resident 1 fell out of her bed and onto the floor. The fall was not witnessed. Staff heard the noise of the fall and responded by finding [resident 1] next to her bed. She continued to seize [a sudden burst of abnormal electrical activity in the brain that may include uncontrolled muscle movement and changes in a person's level of awareness] for many more seconds. [The] Nurse who discovered her [resident 1] called for support. [That nurse] Attempted to grab PRN [as needed] Diazepam nasal spray [a medication used to stop prolonged seizing] but it [that medication] was not present in [the medication] cart. This nurse grabbed PRN Ativan [an anti-anxiety medication that can be used to treat prolonged seizure activity] 0.5 mg [tablet] and administered it buccal [the space between the cheek and the teeth]. Within 10-15 seconds of buccal administration, [the] resident's seizure stopped and she began communicating with staff. The facility had determined that the PRN Diazepam nasal spray was not available to administer to resident 1 because the pharmacy was waiting for the resident's medical provider to complete and return pre-authorization paperwork that was needed to order that medication. According to the facility's investigation, the facility staff contacted resident 1's medical provider and asked that either he promptly complete and return the pre-authorization paperwork or that the provider discontinue the order for the PRN Diazepam nasal spray. The facility's response to not having resident 1's PRN nasal spray available for administration was to ask the pharmacy to notify the facility staff anytime a medical provider failed to promptly complete and return the pre-authorization paperwork to the pharmacy. The facility would then follow up directly with that medical provider. 2. Review of resident 1's electronic medical record (EMR) revealed: A 6/18/25 physician's order: Diazepam intranasal 10 mg, 1 spray in each nostril PRN for status epilepticus [prolonged seizure activity]. A 9/22/25 progress note completed by that same physician included the above PRN Diazepam nasal spray on resident 1's active medication list. Review of resident 1's July 2025 through September 2025 medication administration records (MAR) revealed: A 7/24/25 order for Ativan, 0.5 mg every 24 hours as needed (PRN) for anxiety, seizure disorder. On 9/10/25, that order was discontinued, and Ativan 0.5 mg every 24 hours as needed for anxiety was ordered. A seizure disorder was no longer identified as a clinical indication for administering resident 1's PRN Ativan. 3. Interview on 9/29/25 at 2:10 p.m. with certified medication aide (CMA) F revealed resident 1 did not have PRN Diazepam nasal spray available in the medication cart for administration if the resident had a prolonged seizure. 4. Interview on 9/29/25 at 2:20 p.m. with licensed practical nurse (LPN) C regarding resident 1's PRN Diazepam nasal spray revealed that spray was ordered on 6/27/25 by the resident's medical provider, but the facility did not receive the medication. 5. Interview on 9/29/25 at 4:00 p.m. with DON B revealed resident 1's 9/10/25 PRN Ativan physician's order was incorrectly transcribed in resident 1's EMR to not include that it could be administered to resident 1 for prolonged seizures. DON B confirmed that without an available supply of resident 1's PRN Diazepam nasal spray or physician's orders to administer PRN Ativan for prolonged seizures, resident 1 had no medication to treat a prolonged seizure since 9/10/25. Resident 1 has had no prolonged seizure since that time. DON B stated she had sent a secure electronic message in mid-August 2025 to resident 1's medical provider. An order for an alternative seizure medication for resident 1 and the discontinuation of the PRN Diazepam nasal spray. She had not received any response to that request. DON B confirmed that resident 1's primary medical provider or other medical providers within that medical practice group were in the facility for resident visits no less than three times weekly. DON B did not speak face-to-face with any of those providers regarding an alternate seizure medication option for resident 1 and the discontinuation of the PRN Diazepam nasal spray. Review of the provider's revised 6/15/25 Medication Orders policy revealed: 3. Elements of the Medication Order: [included] j. Diagnosis or indication for use. 4. Documentation of Medication Orders: [included] b. Clarify the order. Review of the provider's revised 6/15/25 Medication Reordering policy revealed: 2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 5. In the event of new orders, the facility is allowed (24) hours to begin a medication unless otherwise specified by the</p>		