

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 10/17/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>43844</p> <p>Based on interview, observation, record review, and policy review, the provider failed to ensure:</p> <p>*Residents maintained a sense of dignity by providing assistance to bathe once per week for 3 of 6 sampled residents (3, 6, and 26).</p> <p>*One of one sampled resident (18) had received staff assistance to change her clothes following one of two observed meal services in the Bistro dining room.</p> <p>*Staff had not stood over 2 of 2 observed residents (26 and 32) to assist them during 2 of 2 observed meal services in the Bistro and main dining rooms.</p> <p>*Two of two observed residents (5 and 29) were dressed in a dignified manner during one of one observed meal service in the main dining room.</p> <p>Findings include:</p> <p>1. Interview and observation on 10/15/24 at 4:39 p.m. of resident 6 with certified nursing assistant (CNA) O in her room revealed:</p> <p>*She was lying in her bed, awake.</p> <p>-Her hair was shoulder-length and appeared to be greasy.</p> <p>*She stated she would like to receive one bath per week but did not always receive one.</p> <p>Review of resident 6's medical record revealed:</p> <p>*Her care plan indicated she preferred one bath per week and needed extensive assistance of one staff member to complete the bath.</p> <p>*Her bathing record indicated the following:</p> <p>-In August 2024 she received a bath on the 2nd, 16th, and 23rd.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--In August 2024 she refused a bath on the 9th and 27th.</p> <p>-In September 2024 she received a bath on the 27th.</p> <p>-In October 2024 she received a bath on the 16th.</p> <p>Review of resident 3's medical record revealed:</p> <p>*Her care plan indicated she was to receive a bath once per week and she required the total assistance of a staff member to complete the bath.</p> <p>*Her bathing record indicated the following:</p> <p>-In August 2024 she received a bath on the 26th and the 28th.</p> <p>-In September 2024 she received a bath on the 4th, 13th, and 18th.</p> <p>-In October 2024 she received a bath on the 2nd and the 16th.</p> <p>Review of resident 26's medical record revealed:</p> <p>*His care plan indicated he required the total assistance of one staff member to complete a bath.</p> <p>*His bathing record indicated:</p> <p>-In August 2024 he received a bath on the 9th, 16th, and 19th.</p> <p>-In September 2024 he received a bath on the 16th, and 23rd.</p> <p>-In October 2024 he received a bath on the 4th.</p> <p>Interview on 10/17/24 at 10:09 a.m. with CNA N regarding resident bathing revealed:</p> <p>*She assisted residents with their bathing.</p> <p>*There was a bath schedule that listed when a resident was to receive a bath.</p> <p>-Most residents took a bath once a week.</p> <p>*Residents' bathing documentation was completed in their electronic medical record (EMR).</p> <p>-She confirmed no documentation of bathing was completed on paper.</p> <p>*When a resident refused a bath, she would notify a nurse.</p> <p>Interview on 10/17/24 at 11:05 a.m. with CNA I regarding resident's bathing revealed:</p> <p>*Residents received one or two baths per week.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*When a resident refused a bath, she would notify a nurse and ask the resident later if they wanted to take a bath.</p> <p>*Residents' bathing documentation was completed in their EMR.</p> <p>Review of residents' bathing documentation and interview on 10/17/24 at 2:45 p.m. with director of nursing (DON) B and administrator A revealed:</p> <p>*Administrator A reviewed residents 3, 6, and 26 bathing documentation and confirmed the baths listed above for each resident was what had been recorded in their EMR.</p> <p>*The resident bath schedule was determined by their preferences identified during their admission process.</p> <p>-Those preferences can change weekly.</p> <p>*Each resident had a staff member advocate that reviewed:</p> <p>-That resident's appearance.</p> <p>-Their bathing documentation.</p> <p>*Visited with the resident at least one time each week and asked them if they had any concerns.</p> <p>-When a resident had a concern, their advocate would assist them in filling out a grievance form.</p> <p>*Documentation of a resident's bath was to be completed in their EMR.</p> <p>-They previously documented residents' baths on a paper form, this process was no longer be used.</p> <p>Review of the provider's February 2018 Bath, Shower/Tub policy revealed:</p> <p>* The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.</p> <p>*Documentation</p> <p>-1. The date and time the shower/tub bath was performed.</p> <p>-2. The name and title of the individual(s) who assisted the resident with the shower/tub bath.</p> <p>-5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken.</p> <p>-6. The signature and title of the person recording the data.</p> <p>*Reporting</p> <p>-1. Notify the supervisor if the resident refuses the shower/tub bath.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The policy did not indicate how often a resident would receive a bath or shower.</p> <p>51472</p> <p>2. Observation on 10/15/24 at 3:25 p.m. during initial tour of resident 18 in her room revealed:</p> <p>*She was lying in her bed with the head of the bed elevated.</p> <p>*A clothing protector was soiled and lying on the floor.</p> <p>*There was no food present at her bedside.</p> <p>*Her shirt was stained and soiled with food.</p> <p>*Her lips had dried food on them.</p> <p>*Her teeth had a layer of food residue on them.</p> <p>*Unknown CNA entered her room in response to her call light and did not address her appearance or clothing protector on the floor.</p> <p>Observation on 10/15/24 at 4:10 p.m. of resident 18 in her room revealed:</p> <p>*Unknown CNAs gowned and entered her room.</p> <p>-She changed her clothing.</p> <p>-She washed her face.</p> <p>-She cleaned her mouth.</p> <p>42558</p> <p>3. Observation on 10/15/24 at 12:10 p.m. during the noon meal service in the main dining room revealed:</p> <p>*Resident 32 was sitting in a wheelchair at a table and was not attempting to eat her meal independently.</p> <p>*She was being assisted with her meal by dietary aide (DA) Q.</p> <p>-DA Q stood next to the resident and spooned a pudding-like dessert into the resident's mouth.</p> <p>-She had not sat down next to the resident when she provided that assistance.</p> <p>-She left the dining room shortly following that observation.</p> <p>47780</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Observation on 10/16/24 at 8:30 a.m. in the Bistro dining room revealed:</p> <p>*Resident 26 was sitting in a wheelchair at a bedside table with a bowl with eggs, a plate with toast, and cups of liquids with straws in them, were placed in front of him.</p> <p>-Unlicensed medication aide/certified nurse aide (MA/CNA) H assisted the resident with eating his eggs while standing rather than sitting down next to the resident.</p> <p>-MA/CNA H walked away while resident 26 started eating his toast independently.</p> <p>-Resident 26 attempted to take a drink from a straw. MA/CNA H returned and stood in front of resident 26 and moved the straw to the resident's mouth. She then moved to his left and continued to stand while assisting him with his meal rather than sitting down next to the resident.</p> <p>-MA/CNA H walked away to talk to another staff member and assisted another resident out of the dining room.</p> <p>*CNA G stood up from assisting a different resident and walked over to an unidentified resident, stood to his left, and assisted him with his oatmeal rather than sitting down next to the resident.</p> <p>Interview on 10/16/24 at 8:47 a.m. with MA/CNA H regarding the above observation revealed:</p> <p>*She stated she had to stand rather than sit next to resident 26 because a chair and the bedside table were not at an equal height.</p> <p>*If she had sat, she was at fist level if he had swung at her.</p> <p>Interview on 10/16/24 at 9:00 a.m. with CNA G regarding the above observation of an unidentified resident revealed she:</p> <p>*Stated, We do what we can.</p> <p>*Stated sometimes he was able to. On the days he cannot feed himself they would have assisted him and that would have included them standing rather than sitting down next to him.</p> <p>Interview on 10/17/24 at 4:26 p.m. with administrator A regarding the above observations revealed:</p> <p>*She had been monitoring the staff for standing during mealtimes rather than sitting down next to the residents.</p> <p>*Staff had received disciplinary action for standing during mealtimes rather than sitting down next to the residents.</p> <p>*Agreed there had been a concern with staff standing during mealtimes rather than sitting down next to the residents.</p> <p>Review of the provider's 2019 The Dining Experience Policy revealed:</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Policy:</p> <p>The dining experience will be person-centered with the purpose of enhancing each individual's quality of life and being supportive of each individual's needs during dining. Individuals will be provided with nourishing, palatable, attractive meals that meet daily nutritional, and/or special dietary needs and food preferences and are served at a safe and appetizing temperature. Individuals will be provided restorative dining services as needed to maintain or improve eating skills.</p> <p>-11. Staff will sit next to a person when assisting them with eating (rather than standing over them).</p> <p>40788</p> <p>5. Observation on 10/16/24 at 5:30 p.m. during the evening meal service in the main dining room revealed:</p> <p>*Resident 29 entered the dining room and then positioned himself in his wheelchair at an angle along the side of the dining table.</p> <p>*He wore a flannel shirt over the top of his t-shirt. -The center button of the flannel shirt was buttoned.</p> <p>*His bare stomach was exposed beneath the bottom edge of those shirts.</p> <p>Continued observation revealed:</p> <p>*Resident 5 entered the dining room and positioned himself in front of a dining table.</p> <p>*His bare stomach was exposed beneath the bottom edge of his green t-shirt.</p> <p>-He was unable to pull his shirt over his stomach to cover it because it appeared too small.</p> <p>Interview on 10/17/24 at 4:50 p.m. with administrator A regarding the above main dining room observations revealed residents 5 and 29 should have been verbally and or physically assisted with their clothing by staff to ensure their dignity had not been compromised.</p> <p>Review of the provider's February 2021 revised Dignity policy revealed: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>51472</p> <p>43844</p> <p>Based on observation, interview, and policy review the provider failed to ensure:</p> <p>*One of three public areas (300 wing) was free of urine odor, a chair did not have a urine odor, and carpet stains.</p> <p>*Two of three sampled residents rooms (12 and 18) were kept in a clean and homelike manner.</p> <p>*Two of three sampled residents rooms (6 and 18) were free of urine odor.</p> <p>1. Observation on 10/15/24 from 9:30 a.m. through 9:45 a.m. of the public area located in the 300 wing revealed:</p> <p>*Lounge chairs in the common area that were made of cloth fabric.</p> <p>-A burgundy lounge chair smelled of urine.</p> <p>*A strong odor of urine was present throughout the area.</p> <p>*Brown stains were on the carpet in multiple locations.</p> <p>2. Random observations on 10/15/24 from 12:45 a.m. through 4:34 p.m. of resident 18's room revealed:</p> <p>*There was a strong odor of urine in resident's 18's room.</p> <p>*A med cup with a dark yellow substance and an empty water glass was on the over-the-bed table.</p> <p>*Multiple creams, mouth swabs, and care items were on the top of the bedside table.</p> <p>*A pile of blankets and clothing was on the recliner.</p> <p>*An open closet door with resident belongings on the floor of the closet.</p> <p>*A gait belt was lying on the bare mattress of the bed.</p> <p>*A television (TV) table with two paper towels covering the TV table.</p> <p>-There was a butter knife and a soiled plastic cup cover on those paper towels.</p> <p>*Present on the floor were:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Black socks in front of the recliner.</p> <p>-A soiled clothing protector on the floor beside the bed.</p> <p>-An open package of incontinent briefs in the hallway just inside the door to the room, visible to anyone walking by.</p> <p>-Multiple wadded up tissues near the bed.</p> <p>-Dirt, dust, and food particles under the bed.</p> <p>Observation on 10/16/24 at 4:14 p.m. and on 10/17/24 at 9:30 a.m. of resident 18's room revealed:</p> <p>*The same observed items as 10/15/24.</p> <p>*Additional items that were observed included:</p> <p>*Present on the floor were:</p> <p>-A open, used, Betadine swab beside the head of the bed.</p> <p>-The wrapper for 4 x 4 gauze drain sponge on the floor in front of the bedside table.</p> <p>*Sit to stand sling was lying on the bare mattress of the bed.</p> <p>Interview on 10/16/24 at 4:44 p.m. with unlicensed medication aide/certified nurse aide (UMA/CNA) V regarding resident 18's room revealed:</p> <p>* When asked about the condition of the room he picked up some of the objects that were on the TV table and over the bed table.</p> <p>*Another CNA entered the room and made the bed.</p> <p>Interview on 10/17/24 at 4:32 p.m. with administrator A regarding resident 18's room revealed she stated, I'll have to check on it.</p> <p>Record review on 10/17/24 at 11:30 related to resident 18 revealed:</p> <p>*Her diagnoses included multiple communicable diseases that included hepatitis C and multi-drug resistant organisms.</p> <p>*She had a stroke affecting her dominant right side.</p> <p>-Her right hand was contracted.</p> <p>*She had an impaired immune system related to her chronic diseases.</p> <p>*Her care plan included she was at a high risk for infection.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-She was on contact and enhanced barrier precautions (use of personal protective equipment such as gloves, gown, and/or eyewear).</p> <p>*She had a suprapubic catheter (tube surgically placed to drain urine) and required assistance from a staff member for suprapubic catheter care.</p> <p>3. Interview on 10/15/24 at 11:37 a.m. with resident 12's daughter revealed:</p> <p>*She felt that the building and grounds were not cared for.</p> <p>*She stated that the facility smelled of urine and was dreary.</p> <p>*She stated that this was the fourth room that her mother had been in, since her admission on 8/16/23, and this room was cleaner than the previous rooms.</p> <p>*She reported that prior to the family having purchased sheets for her mother's bed, the bottom sheets often had holes in them and there was no top sheet on the bed.</p> <p>*She had witnessed that often the residents' beds were not made.</p> <p>*She stated that she had filed a grievance previously, but she did not feel that a change was made.</p> <p>4. Observation on 10/17/24 at 11:45 a.m. of resident 6's room revealed a distinct odor of urine.</p> <p>5. Interview on 10/17/24 at 2:45 p.m. with director of nursing B and administrator A revealed:</p> <p>*Each resident had a staff member advocate that reviewed:</p> <p>-That resident's appearance.</p> <p>-Cleanliness of their room and any non-cleanable surfaces.</p> <p>*Visited with the resident at least one time each week and asked them if they had any concerns.</p> <p>-When a resident had a concern, their advocate would assist them in filling out a grievance form.</p> <p>47780</p> <p>6. Interview on 10/17/24 at 2:35 p.m. with housekeeper U revealed:</p> <p>*She cleaned the hallway floors, both dining rooms and the residents' rooms daily.</p> <p>*Cleaning of the residents' rooms included she:</p> <p>-Removed trash bags from the trash cans and placed a clean trash bag in the trash can.</p> <p>-Swept the floors with a dry mop.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>51472</p> <p>Based on interview, record review and policy review the provider failed to investigate one of one injury of unknown origin for one of one sampled resident (12) findings include:</p> <p>1. Interview with resident 12's daughter on 10/15/24 at 11:37 a.m. revealed:</p> <p>*Resident 12 was sent to the emergency department on 9/24/24 due to an unresponsive episode.</p> <p>*Upon return to the facility, staff transferred resident 12 with a sit-to-stand lift.</p> <p>- One of resident 12's daughters noted her left leg was unstable and informed the staff member that was performing the transfer.</p> <p>*On 9/26/24 family of resident 12 demanded X-ray of resident 12's left leg.</p> <p>Review of resident 12's electronic medical record (EMR) revealed:</p> <p>*A 9/25/24 nurses note documented: c/o [complaints of] pain when moving the leg out or when the area above the knee is touched. No edema and no known injury.</p> <p>*On 9/26/24 she was seen by a Certified Nurse Practitioner.</p> <p>- On 9/26/24 an X-ray was ordered and an acute, displaced oblique fracture through the distal femoral diaphysis was diagnosed .</p> <p>Interview with director of nursing (DON) B on 10/16/24 at 3:45 p.m. regarding resident 12's fracture revealed:</p> <p>*On 9/25/24 she was notified of resident 12's left leg pain early in the a.m.</p> <p>* On 9/25/24 at 8:52 a.m. she notified the primary care provider of resident 12's left leg pain and her family was aware.</p> <p>-She received an order for an X-ray.</p> <p>-Family was present and aware of the X-ray order.</p> <p>*She stated that there was no known cause of resident 12's fracture and she had a history of pathological fractures.</p> <p>*She confirmed that she had not reached out to the emergency department to inquire about resident 12's pain or injury during her 9/24/24 visit.</p> <p>*She confirmed that she had not reported resident 12's fracture to any outside agency such as the South Dakota Department of Health (SD DOH).</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*She confirmed there was no documentation to support an investigation was completed.</p> <p>Review of the provider's September 2022 Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy revealed All reports of resident abuse (including injuries of unknown origin), neglect, exploitation or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.</p>		

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NAME OF PROVIDER OR SUPPLIER Rolling Hills Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 13th Ave Belle Fourche, SD 57717	
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>43844</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure 5 of 8 sampled residents (6, 18, 26, 29, and 46) had their care plans followed, updated, and revised promptly to reflect their current status and care needs. Findings include:</p> <p>1. Observation on 10/15/24 at 3:25 p.m., during the initial tour, of an unknown certified nursing assistant (CNA) revealed:</p> <p>*That CNA responded to resident 18's call light and asked resident 18 if she needed to put a gown on. -Resident 18 nodded no and the CNA exited the room.</p> <p>Observation on 10/15/24 at 4:10 p.m. of the same CNA above revealed she put a gown and gloves on prior to entering Resident 18's room.</p> <p>Review of resident 18's 10/16/24 care plan revealed:</p> <p>*A focus area indicated she had a compromised immune system.</p> <p>-An intervention for this focus area directed: Staff will follow contact precautions with providing cares to resident per M.D. orders.</p> <p>*A focus area that indicated she had an autoimmune disease and the potential for complications.</p> <p>-An intervention for this focus area directed: Enhanced Barrier Precautions (EBP) for high contact care activities PMH [past medical history] of ESBL [a bacterial infection resistant to some antibiotics] in urine.</p> <p>Interview on 10/17/24 at 9:55 a.m. with CNA I regarding precautions for resident 18 revealed she did not know the name of the precautions but stated she wore a gown when she provided direct care for resident 18.</p> <p>Interview on 10/17/24 at 10:04 a.m. with registered nurse (RN) J regarding resident 18 was on revealed she stated that resident 18 was on contact precautions.</p> <p>Interview on 10/17/24 at 10:13 with director of nursing (DON) B regarding the type of precautions that resident 18 was on revealed:</p> <p>*She confirmed that resident 18 was on EBP.</p> <p>*She confirmed that resident 18 had previously been on Contact Precautions.</p> <p>-The contact precautions were recently lifted due to resident 18's CD4 count [test that measures the number of white blood cells in the blood] being within normal limits.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Observation on 10/17/24 at 9:30 a.m. revealed resident 18's AFO (brace that stabilizes and controls the range of motion of the foot and ankle) revealed:</p> <p>*Brace was lying on the floor of her closet.</p> <p>Review of resident 18's 10/16/24 care plan revealed a focus area that indicated I [resident 18] have a right lower extremity AFO that I am to wear for all ADL [activities of daily living] transfers and ambulation as tolerated.</p> <p>Review of resident 18's 8/27/24 Physical Therapy PT Evaluation & Plan of Treatment revealed:</p> <p>*She was dependent on staff assistance with all transfers.</p> <p>*Ambulation was marked as Not applicable.</p> <p>Interview on 10/17/24 at 9:55 a.m. with CNA I regarding the use of the AFO for transfers and ambulation revealed:</p> <p>*She had not used the AFO on resident 18 Since I started working here.</p> <p>-CNA clarified that she had been employed there for greater than one year.</p> <p>*Resident 18 transfered solely with a sit-to-stand lift (mechanical lift used to transfer from a seated position to standing).</p> <p>*Resident 18 does not ambulate.</p> <p>Interview on 10/17/24 at 10:04 a.m. with RN J regarding the use of resident 18's AFO for transfers and ambulation revealed:</p> <p>*She confirmed that the AFO was discontinued by the physician orders.</p> <p>*She confirmed that resident 18 was transfered solely with the use of a sit-to-stand lift.</p> <p>*She confirmed that resident 18 did not ambulate.</p> <p>Interview on 10/17/24 at 10:30 a.m. with DON B regarding the use of the AFO for transfers and ambulation revealed she did not believe the AFO was still in use for resident 18.</p> <p>3. Observation and interview on 10/15/24 at 11:23 a.m. with resident 29 revealed:</p> <p>*He was seated in a wheelchair.</p> <p>-His left foot was strapped to the wheelchair pedal with a Velcro strap.</p> <p>-His left arm was strapped to an arm support on the wheelchair with a Velcro strap.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-A 7/17/24 focus area indicated his diet was EASY TO CHEW.</p> <p>--An intervention for this focus area included Educate patient on nutrient restriction and on risks of not following diet restrictions.</p> <p>5. Observation on 10/15/24 at 3:23 p.m. of resident 26 revealed:</p> <p>*He was in the lobby area watching television.</p> <p>*He was seated in a wheelchair with an unlatched seat belt attached to it.</p> <p>Review of resident 26's medical record revealed:</p> <p>*His BIMS assessment was not able to be completed.</p> <p>-A staff assessment of his cognition on 8/13/24 indicated his cognition was moderately impaired.</p> <p>*His diagnoses included: dependence on wheelchair, convulsions, epilepsy, and hemiplegia (paralysis) affecting his left side.</p> <p>*A 10/10/22 physician order for Wheelchair Seatbelt: Release for 20 mins [minutes] every 2 hours while seatbelt is in use.</p> <p>*His 10/16/24 care plan did not include any information regarding the use of a seat belt on his wheelchair.</p> <p>Interview on 10/16/24 at 6:35 p.m. with CNA S regarding resident 26's use of a seat belt revealed:</p> <p>*He used a seat belt when seated in his wheelchair.</p> <p>-He would often remove it himself.</p> <p>-A staff member would reattach it around his waist when he removed it.</p> <p>Interview on 10/17/24 at 7:59 a.m. with administrator A regarding resident 26's seat belt use revealed:</p> <p>*His wheelchair was custom fit to his needs.</p> <p>-There was a non-removable seatbelt attached to his wheelchair.</p> <p>-He was able to unlatch the seat belt from around himself.</p> <p>-He had stopped using the seat belt when in his wheelchair.</p> <p>-Some staff members had still placed and latched it around him.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/17/24 at 11:04 a.m. with CNA I regarding resident 26's use of a seat belt when seated in his wheelchair revealed he only wore the seat belt when going for a bus ride.</p> <p>Interview on 10/17/24 at 11:42 a.m. with DON B regarding resident 26's seatbelt use revealed:</p> <p>*He removed the seat belt as soon as it was placed around him.</p> <p>-She was not aware if he used it when on a bus ride.</p> <p>6. Observation on 10/17/24 at 10:27 a.m. of resident 6 in her room revealed a strip of blue tape, approximately 2 inches by 4 inches across the top inside edge of her headboard.</p> <p>Review of resident 6's 10/16/24 care plan revealed:</p> <p>*There was a focus area that she was at risk for falls.</p> <p>-The intervention for this focus area included BED HEIGHT: When in Standard position [the bed was] to be 35.5 inches per Blue Tape visual marking on wall.</p> <p>Interview on 10/17/24 at 11:15 a.m. with CNA I regarding the height a resident's bed should be revealed:</p> <p>-When there was a blue strip of tape on the wall, that is where a resident's bed height should be.</p> <p>-She confirmed resident 6's bed should have a strip of blue tape on the wall and the headboard.</p> <p>--There was no blue tape on the wall.</p> <p>-She would just eyeball it to ensure it was at the right height.</p> <p>Interview on 10/17/24 at 11:22 a.m. with DON B regarding the height of residents' beds revealed:</p> <p>*There was a piece of blue tape on the wall and on the head of the bed that were to match up to ensure the proper height of the bed for that resident.</p> <p>*Everyone was responsible for ensuring the tape was in place.</p> <p>-No one was assigned to complete a routine check of tape to ensure it was in place.</p> <p>-Her expectation was for the tape to be replaced when it was missing.</p> <p>7. Interview on 10/17/24 at 11:32 a.m. with DON B regarding residents care plans revealed:</p> <p>*The interdisciplinary team (IDT), including the dietary manager, Minimum Data Set (MDS) nurse, social service staff member, director of nursing, and the administrator would meet to discuss any changes to the care a resident may require.</p> <p>*The MDS Nurse would update the care plan or assign another IDT member to update it.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Individual resident care plans were to be updated as needed, including resolving issues in the care plan when needed.</p> <p>8. Review of the provider's March 2022 Care Plans, Comprehensive Person-Centered policy revealed:</p> <p>*A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p> <p>*The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.</p> <p>*The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.</p> <p>*Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to:</p> <ul style="list-style-type: none"> -receive the services and/or items included in the plan of care; <p>*The comprehensive, person-centered care plan:</p> <ul style="list-style-type: none"> -Includes measurable objectives and timeframes; -Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . <p>*Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.</p> <p>*When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.</p> <p>*Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.</p> <p>*The interdisciplinary team reviews and updates the care plan:</p> <ul style="list-style-type: none"> -a. when there has been a significant change in the resident's condition; -b. when the desired outcome is not met; -c. when the resident has been readmitted to the facility from a hospital stay; and -d. at least quarterly, in conjunction with the required quarterly MDS assessment. <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>51472</p> <p>Based on observation, interview, record review, and policy review the provider failed to ensure:</p> <p>*Two of two residents (12 and 35) who had an oxygen concentrator in their room and did not have a physicians order for oxygen administration.</p> <p>*One of one sampled resident (18) used a physician's ordered therapeutic boots.</p> <p>*One of one sampled resident (6) meal documentation was accurate for one of one meal by one of one certified nursing assistant (CNA) (I).</p> <p>*One of one sampled resident (29) had been assessed for restraint use of Velcro straps holding his foot and arm in a secure position.</p> <p>*One of one sampled resident (25) who self-administered medication had his self-administration assessment completed accurately.</p> <p>1. Observation on 10/15/24 at 11:24 a.m. of resident 12's room revealed:</p> <p>*An oxygen concentrator was at her bedside.</p> <p>*Oxygen tubing was attached to the concentrator and was draped over the top of it.</p> <p>Interview on 10/15/24 at 11:37 a.m. with resident 12's daughter regarding oxygen use revealed:</p> <p>*The oxygen concentrator had been used as needed by resident 12 since she returned from the emergency department on 9/24/24.</p> <p>-Resident 12 had required oxygen most often in the morning after sleeping.</p> <p>Review of Resident 12's electronic medical record (EMR) oxygen use revealed:</p> <p>*There was no physician order for the administration of oxygen.</p> <p>*The care plan did not include her use of oxygen.</p> <p>Interview on 10/17/24 at 10:13 a.m. with director of nursing (DON) B regarding resident 12's use of oxygen revealed she:</p> <p>*Confirmed there was no order for oxygen for resident 12.</p> <p>*Was not aware of resident 12's oxygen use.</p> <p>-Stated that the oxygen concentrator in that room was for resident 35.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident 35's EMR use of oxygen revealed no order for oxygen for resident 35.</p> <p>2. Observation on 10/17/24 at 09:30 a.m. of resident 18's room revealed:</p> <p>*An AFO (brace that stabilizes and controls the range of motion of the foot and ankle) was lying on the floor in the resident's closet.</p> <p>*There were no other braces or boots visualized in the room.</p> <p>Interview on 10/17/24 at 9:55 a.m. with CNA I regarding resident 18's use of brace/boots for her legs at night revealed she:</p> <p>*Had been employed there for greater than one year.</p> <p>*She had not removed braces from resident 18, in the morning, in the time she had worked there.</p> <p>Interview on 10/17/24 at 10:04 a.m. with registered nurse (RN) J regarding the use of braces or boots at night for resident 18 revealed she:</p> <p>*Did not think resident 18 wore braces or boots at night.</p> <p>*Was only able to locate the AFO in resident 18's room.</p> <p>Interview on 10/17/24 at 10:13 a.m. with DON B regarding resident 18's use of braces or boots at night revealed:</p> <p>*There were two physician orders for therapeutic boots to be worn at night.</p> <p>*She stated that the AFO in resident 18's closet is the same as a Multipodus boot (a device worn on the calf and foot that suspends the heel and holds the ankle at a 90-degree position to remove pressure from the back of the heel and counteract muscle tightness).</p> <p>Interview on 10/17/24 at 10:30 a.m. with Director of Rehab (DOR) L regarding resident 18's use of braces or boots at night revealed:</p> <p>*She confirmed that a Multipodus boot and an AFO brace are not the same.</p> <p>*She confirmed there were two orders in resident 18's physician orders for boots to be worn at night.</p> <p>- A Multipodus boot was ordered for the right foot.</p> <p>- A Thera-boot (leg compression boots to improve circulation) order did not specify a side.</p> <p>*She confirmed with physical therapist K that there was not a Thera-boot or a Multipodus boot in resident 18's room.</p> <p>Review of resident 18's electronic (EMR) use of therapeutic boots at night revealed:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*There were two physician orders for therapeutic boots to be worn at night.</p> <p>- An order on 7/23/21 instructed to Ensure wearing thera-boot at night.</p> <p>--It was scheduled on the treatment administration record (TAR) for every evening shift.</p> <p>--There was no designation if it was to be worn on the right, left, or both feet.</p> <p>-An order on 7/23/21 for Multipodus boot on Right foot at bedtime.</p> <p>--It was scheduled on the TAR for every night at bedtime.</p> <p>*Her 10/17/24 care plan did not include the Multipodus boot or the Thera-boot.</p> <p>43844</p> <p>3. Observation and interview on 10/15/24 at 4:39 p.m. of CNA O and resident 6 revealed:</p> <p>*Resident 6 was lying in her bed, awake.</p> <p>*There was a bedside table next to the bed.</p> <p>-On this table was a meal tray and a plate of food from lunch that was untouched.</p> <p>*Resident 6 stated she had a significant weight loss a while ago.</p> <p>*CNA O asked resident 6 if she had eaten.</p> <p>-Resident 6 responded she had forgotten that her lunch tray was there.</p> <p>Review of resident 6's EMR revealed:</p> <p>*Her diagnoses included: anorexia, depression, moderate protein-calorie malnutrition, diabetes, acute kidney failure, macular degeneration, dizziness, muscle weakness, cognitive communication deficit, and need for assistance with personal care.</p> <p>*Her weight record indicated she weighed 125.5 pounds (lbs.) on 4/2/24 and 106 lbs. on 10/1/24.</p> <p>*Her care plan included:</p> <p>-She was at nutritional risk due to her diagnoses.</p> <p>-She preferred to dine in her room.</p> <p>-A staff member was to tell her where her food items were on the plate using the clock method.</p> <p>--She was able to eat independently after a staff member set up her meal.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff members were to document the percentage of her meal intake on a tracking form.</p> <p>*Review of resident 6's meal intake tracking form revealed that on 9/15/24 CNA I documented she had eaten 26 to 50 percent (%).</p> <p>Interview on 10/17/24 at 11:05 a.m. with CNA I regarding resident meal intake documentation revealed:</p> <p>*Documentation of meals was completed by whomever picked up the meal tray from a resident's room.</p> <p>*She confirmed that on 10/15/24 she documented that resident 6 had eaten her lunch at 26 to 50% as that is what she normally eats.</p> <p>-She confirmed she had not observed or picked up resident 6's lunch tray on 10/15/24.</p> <p>Interview on 10/17/24 at 11:25 a.m. with DON B regarding the documentation of resident meal intake revealed:</p> <p>*The person responsible for documenting what a resident had eaten was the person who removed the tray from the resident's room after the meal.</p> <p>-That person was usually a CNA.</p> <p>*She stated, Everyone has issues with documentation and she would have expected documentation to be accurate.</p> <p>4. Observation and interview on 10/15/24 at 11:23 a.m. with resident 29 revealed:</p> <p>*He was seated in a wheelchair.</p> <p>-His left foot was strapped to the wheelchair pedal with a Velcro strap.</p> <p>-His left arm was strapped to an arm support on the wheelchair with a Velcro strap.</p> <p>*He stated he was unable to remove either Velcro straps on his own.</p> <p>Review of resident 29's EMR revealed there was no assessment completed to determine if the Velcro straps on his left foot and arm were restraints.</p> <p>Interview on 10/17/24 at 10:09 a.m. with CNA N regarding resident 29 revealed a staff member assisted resident 29 with placement of the Velcro straps to his left foot and left hand.</p> <p>Interview on 10/17/24 at 11:12 a.m. with CNA I regarding resident 29's use of Velcro straps revealed:</p> <p>*He used them to stabilize his hand and foot.</p> <p>*He asked staff to attach the Velcro straps to his hand and foot each day.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/17/24 at 11:34 a.m. with director of nursing B regarding assessing resident 29's Velcro straps as a possible restraint revealed:</p> <p>*The straps had not been assessed as a restraint as he had requested the use of them.</p> <p>Review of the provider's April 2017 Use of Restraints policy revealed:</p> <p>*Policy interpretation and Implementation</p> <p>-1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.</p> <p>-6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints.</p> <p>5. Observation on 10/15/24 at 11:34 a.m. of resident 25 revealed:</p> <p>*He was seated in a recliner in his room.</p> <p>*He was holding a nebulizer mask up to his face.</p> <p>Review of resident 25's medical record revealed:</p> <p>*His diagnoses included chronic obstructive pulmonary disease (COPD), Bronchiectasis (a chronic lung disease that causes the airways of the lungs to widen and become permanently damaged), cognitive communication deficit, and acute respiratory failure with hypoxia.</p> <p>*His 8/2/24 BIMS assessment score was 14, which indicated his cognition was intact.</p> <p>*There was a 3/14/24 physician order for Albuterol Sulfate Nebulization Solution.</p> <p>*An 8/1/24 self-administration of medication evaluation did not include the medications he was able to self-administer.</p> <p>Interview on 10/17/24 at 11:20 a.m. with DON B regarding self-administration of medication evaluations revealed:</p> <p>*Self-administration of medication evaluations were to be completed for residents who wanted to self-administer medications.</p> <p>-This evaluation was completed by a nursing staff member on a quarterly basis.</p> <p>*She confirmed that the 8/1/24 self-administration of medication evaluation for resident 25 did not include what medications he was able to self-administer.</p> <p>-Her expectation was for the medications to be listed on the evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. Review of the provider's October 2023 Resident Assessments policy revealed:</p> <p>*The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments.</p> <p>*All members of the care team, including licensed and unlicensed staff members, are asked to participate in the resident assessment process.</p> <p>7. Review of the provider's undated Conformity with Laws and Professional Standards policy revealed:</p> <p>*Our facility operates and provides services in compliance with current federal, state, and local laws, regulations, codes and professional standards of practice that apply to our facility and types of services provided.</p> <p>*Our facility's policies, procedures, and operational practices are developed and maintained in accordance with current accepted professional standards and principles as well as current commonly accept health standards established by national organizations, board and councils.</p> <p>*Our facility has developed written policies and procedures that govern day-to-day operation and such policies and procedures are reviewed at least annually.</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>43844</p> <p>Based on interview, observation, record review, and policy review, revealed the provider failed to ensure one of one sampled resident's (3) pressure injuries had been identified, assessed, documented, and her physician was notified. Findings include:</p> <p>1. Interview on 10/16/24 at 8:05 a.m. with director of nursing (DON) B regarding resident 3's Stage III pressure ulcer that was listed on the facility provided Matrix revealed that pressure ulcer was healed at the beginning of September 2024.</p> <p>Interview on 10/17/24 at 10:09 a.m. with certified nursing assistant (CNA) N regarding resident 3's skin concern revealed:</p> <p>*She had sores on her buttock and on her inner thigh, one [is the] size of [a] quarter [the] other's [the] size of [a] dime.</p> <p>-She had sores on her heels in the past, but currently did not.</p> <p>*She had notified licensed practical nurse (LPN) M of the sores.</p> <p>Interview on 10/17/24 11:05 AM with CNA I regarding resident 3's skin revealed:</p> <p>*She had a little tiny one [sore] in between her thighs.</p> <p>-She thought a nurse was aware.</p> <p>Interview on 10/17/24 at 11:29 a.m. with DON B regarding resident 3's skin condition revealed:</p> <p>*She did not currently have any pressure injuries.</p> <p>-She had pressure injuries on both of her heels in the recent past that had healed.</p> <p>Review of resident 3's electronic medical record (EMR) revealed:</p> <p>*Nurse's progress notes that indicated:</p> <p>-On 9/6/24 area of breakdown to the back of Achilles heel.</p> <p>--The areas are not open and the L [left] heel at 1.5 cm [centimeters] long is worse than the R [right] at 1.0 cm long. Both measuring approximately 0.6 cm wide. Origin unknown.</p> <p>-On 9/11/24 Resident has two pressure areas to bilateral heels. R heel measurement (cm): 0.3 x 0.3 L heel measurement (cm) 0.4 x 1.4. Right heel is a small fully ruptured blister that has [that has] a small open area where all fluid has drained out and epithelial tissue remains intact otherwise.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-On 9/18/24 Resident had been on weekly wound rounds for a small blister to each heal [heel] and both are now healed.</p> <p>Observation and Interview on 10/17/24 at 3:00 p.m. with assistant director of nursing (ADON) C regarding resident 5's skin concern revealed:</p> <p>*Left proximal posterior upper leg with an open area that was an approximate size of 0.4 cm by 0.4 cm open area with 2 cm by 6 cm of raised nonblanchable skin surrounding the open area.</p> <p>*Left proximal posterior heel at approximately 0.2 cm x 0.5 cm that she identified as a suspected deep tissue pressure injury.</p> <p>*ADON C confirmed that she was not previously aware of resident 3's current skin issues, she wishes someone would have told me about it.</p> <p>Interview on 10/17/24 at 3:15 p.m. with registered nurse (RN) T regarding resident 3's skin condition revealed:</p> <p>*Her thighs were excoriated (skin was wearing off).</p> <p>*No staff member had asked for a silicone patch to be placed on her skin to assist in the prevention of a pressure injury.</p> <p>-She was not aware of resident 3 having pressure injury.</p> <p>Interview on 10/17/24 at 3:19 p.m. with RN J regarding resident 3's skin condition revealed:</p> <p>*She completed a skin assessment on 10/16/24.</p> <p>-She had looked at [her] bottom and looked at [her] heel she had not seen anything unusual.</p> <p>-After discussion of resident 3's pressure ulcer's on her posterior upper leg and posterior heel she stated, Those don't happen overnight.</p> <p>Interview on 10/17/24 at 3:30 p.m. with CNA N regarding resident 3's skin condition revealed:</p> <p>*She had notified nurse licensed practical nurse M a week previous that her bottom was open at that time and it wasn't big but open, right where [her] leg and butt cheek connect.</p> <p>*She stated she thought other nurses had been aware of the skin concern.</p> <p>Interview on 10/17/24 at 3:35 p.m. with DON B regarding resident 3's current pressure injuries revealed:</p> <p>*She confirmed the pressure injuries had not been assessed, documented, and her physician notified.</p> <p>*Her expectation for pressure injuries was that:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-A professional nurse was to complete a full head-to-toe skin assessment.</p> <p>-The resident's physician was to be contacted with any concerns.</p> <p>-A risk management report was to be completed.</p> <p>Review of the provider's April 2018 Pressure Ulcers/Skin Breakdown-Clinical Protocol policy revealed:</p> <p>*The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s).</p> <p>*In addition, the nurse shall describe and document/report the following:</p> <p>-a. Full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue;</p> <p>Review of the provider's March 2020 Pressure Injuries Overview policy revealed:</p> <p>*Staging (National Pressure Injury Advisory Panel Classification System)</p> <p>*Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration</p> <p>-Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation reveals a dark wound bed or blood-filled blister.</p> <p>-This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.</p> <p>*The wound mat [may] evolve rapidly to reveal the actual extent of tissue injury, or many [may] resolve without tissue loss.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40788</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure:</p> <p>*Food plated for residents who received late, in-room mealtrays during one of one observed meal service were served at an appetizing temperature.</p> <p>*One of one resident's (43) room trays were delivered in a timely manner to ensure food temperatures were appetizing during two of two observed meal services.</p> <p>Findings include:</p> <p>1. Observation on 10/16/24 from 5:05 p.m. through 6:10 p.m. of the evening meal service and interviews with cook F during that same time revealed:</p> <p>*Food for the evening meal was temped in the kitchen before placing it on the steam table in the main dining room (MDR) prior to serving.</p> <p>-Hot foods were all at an acceptable serving temperature.</p> <p>*Cook F plated the evening meals for residents in the following order:</p> <p>-Regular room trays (room trays for residents who regularly ate their meals in their rooms), the Bistro dining room, the MDR, and late trays (residents who usually ate in the Bistro or the MDR but had chosen to eat in their rooms for that meal).</p> <p>*At 5:05 p.m. cook F began plating the regular room trays using plates removed from a dual plate warmer.</p> <p>-Plates inside the two cylinders of the warmer rose six to eight inches above the lip of each cylindher cylinder opening that prevented those plates from being warmed.</p> <p>*A red light on the right side warmer was lit which indicated the warming cylinder was on but the light on the left side warmer was unlit.</p> <p>-Cook F thought the left side warmer may not have been working properly.</p> <p>*Instructions on top of the warmer read: Adjust thermometer inside tube.</p> <p>-Cook F had not known at what temperature the thermometer inside each tube was set at</p> <p>*Maintenance director D was responsible for making temperature adjustments to the warmer.</p> <p>-She had not discussed her concerns regarding the left side warmer with him.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*Regular room trays and the portable steam table used to serve meals in the Bistro left the MDR for resident distribution at 5:15 p.m.</p> <p>*Residents sitting in the hall outside of the MDR were allowed into the MDR at 5:15 p.m.</p> <p>-MDR residents were scheduled to receive their meals at 5:30 p.m.</p> <p>*Between 5:15 p.m. and 5:30 p.m. cook F and dietary aide R had taken drink orders from the residents in the MDR and assisted them to complete their menus for the following days meals.</p> <p>-During that same time, the food containers on the steam table had been left uncovered.</p> <p>*Cook F stated the only food-related complaint she had heard from residents was lately their food had been cold.</p> <p>*At 5:40 p.m. plating and serving of the evening meal for residents in the MDR began.</p> <p>*At 6:00 p.m. the following temperatures were taken from the uncovered food containers on the steam table immediately before the late resident room trays were plated:</p> <p>-Mashed potatoes/122 degrees Fahrenheit (F), asparagus/102 degrees F, gravy/78 degrees F, and fish/80 degrees F.</p> <p>*Cook F indicated she had lowered the temperature on the steam table so the gravy would not burn.</p> <p>-That had likely affected the temperatures of all the other food held on that steam table.</p> <p>-The length of time it had taken to serve all the residents, the uncovered containers on the steam table, and the possibility the plate warmer may not have been functioning properly and may also have contributed to the low food temperatures.</p> <p>*Frozen ice cream cups were the dessert for that same evening meal.</p> <p>-A box of 48 stacked ice cream cups sat directly on top of a Blue Ice re-usable freezer pack in the MDR food serving station area.</p> <p>*Cook F confirmed the ice cream cups were soft and runny by the time they were served to residents who received late trays.</p> <p>2. Observation and interview on 10/17/24 at 9:15 a.m. with maintenance director D of the dual plate warmer revealed:</p> <p>*The temperature gauge inside of both warmers was set between 1 and 2.</p> <p>-The plate warmer guide inside of the warmers regarding plate warmer temperatures indicated the following: Warm=1 and 5=Hot.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/17/24 at 4:30 p.m. with administrator A regarding food holding temperatures revealed:</p> <ul style="list-style-type: none"> *Hot food temperatures were not held and served at an expected temperature of at least 135 degrees F. *Frozen food was not kept at a temperature to prevent thawing from occurring. *There were opportunities to improve the food service delivery process to ensure food temperatures for all meal services were kept at an appetizing temperature. <p>42558</p> <p>3. Observation and interview on 10/15/24 at 12:47 p.m. with resident 43 while in his room located in the 200-hallway revealed:</p> <ul style="list-style-type: none"> *He was fully reclined in his recliner chair with oxygen being delivered by nasal cannula. *He stated he attended renal dialysis on Mondays, Wednesdays, and Fridays. *He had requested the noon meal to be delivered to his room. *He stated: <ul style="list-style-type: none"> -He hoped his food would arrive soon because he was hungry. -I never know when I will get it [this meal tray]. -It was his preference to eat his meals in his room so he could avoid sitting on a sore that was on his tailbone. -The hot food was always cold by the time the meal trays arrived. -He did not like most of the foods that were served to him. -He had quit filling out the meal preference sheets because he never received what he had ordered. -He sent his meal trays back to the kitchen in the past, but no alternatives were offered, and his food was never heated up and returned, so he had quit asking. <p>Interview on 10/15/24 at 12:55 p.m. with dietary aide Q regarding meal tray service to the resident rooms revealed:</p> <ul style="list-style-type: none"> *The noon meal service started at noon. *She stated the late room trays were normally delivered at 12:40 p.m. following the dining room meal service, but she was running a little bit late. <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-There were early meal trays that were delivered before the dining room service for those who always stayed in their rooms, and late meal trays were delivered following the dining room service for those residents who occasionally requested a tray for their room.</p> <p>Further interview on 10/15/24 at 1:04 p.m. with resident 43 in his room revealed he had not received his noon meal tray and he stated he was becoming angry because he was very hungry.</p> <p>Observation on 10/15/24 from 1:09 p.m. through 1:27 p.m. of the nurse's station adjacent to the 200-hallway revealed:</p> <p>*At 1:09 p.m. the plated and covered meal trays were delivered on a cart to the nurse's station, and staff were notified by walkie-talkie that the trays were ready to be delivered.</p> <p>*At 1:12 p.m. the tray cart remained sitting by the nurse's station while four unidentified staff members visited behind the nurse's desk.</p> <p>*At 1:19 p.m. an unidentified resident walked up to the covered meal tray cart and lifted the lid off a tray to view the food, removed a lid off a drink, took a sip, and then replaced those lids.</p> <p>-That tray was immediately removed from the cart by a staff member and taken back to the kitchen.</p> <p>-That meal cart was then taken down each hallway for delivery of the late room trays.</p> <p>-An unidentified aide walked the meal cart past resident 43's room twice without delivering any food to him nor explaining to the resident why his tray was late. Resident 43 continued to wait for his lunch meal.</p> <p>*At 1:27 p.m. resident 43 was delivered a noon meal tray to his room.</p> <p>-That was eighteen minutes after the meal cart had been delivered to the nurse's station and over forty-five minutes past the normal late tray delivery time.</p> <p>Observation and interview on 10/15/24 at 1:27 p.m. and at 3:47 p.m. with resident 43 following delivery of his noon meal tray revealed:</p> <p>*He stated his pulled-meat barbeque sandwich and his potato wedges were cold.</p> <p>-He had requested hot water and a green tea bag and was served a cup of slightly warm coffee along with a sealed green tea bag. He had no hot water for the tea bag.</p> <p>*He stated, I'll eat the coleslaw only. It's [the food] crap. It's always cold.</p> <p>*At 3:47 p.m., observation of resident 43's room revealed his noon meal tray remained sitting on his table next to his recliner with the uneaten barbeque sandwich and potato wedges.</p> <p>4. Observation, interview, and food temperature monitoring on 10/16/24 from 5:28 p.m. through 6:25 p.m. with resident 43 and his former wife while he awaited a meal tray to be delivered to his room revealed:</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*His meal tray arrived at 5:29 p.m. and contained baked fish with an internal temperature of 100.4 degrees, mashed potatoes at 103.7 degrees, and asparagus at 90 degrees.</p> <p>-The resident stated he hated fish and that he would only eat the asparagus.</p> <p>-His ice cream cup dessert had melted and was mostly liquified.</p> <p>-He admitted he had not filled out a meal preference ticket for that meal and stated, It's a waste of time because they won't give me what I want.</p> <p>*At 5:30 p.m., he asked his former wife to order him some chicken noodle soup. She went to the adjacent nurse's station and placed a request for the soup.</p> <p>*At 6:25 p.m. he had not received his requested soup and no staff had come into his room to check on his meal or to remove his meal tray.</p> <p>Interview on 10/16/24 at 6:26 p.m. with assistant director of nursing (ADON) C who was at the adjacent nurse's station regarding the soup request for resident 43 revealed:</p> <p>*None of the four staff members who were at the nurse's station had been there when the resident's former wife requested the soup at 5:30 p.m.</p> <p>*ADON C stated, Whoever was at the desk should have called the kitchen on the phone.</p> <p>Interview on 10/16/24 at 6:27 p.m. with dietary aide (DA) R in front of the adjacent nurse's station while he was pushing the meal cart with used meal trays to the kitchen revealed:</p> <p>*He confirmed he had heard about resident 43's request for soup.</p> <p>-He stated, I think we forgot. I'm sorry.</p> <p>*He confirmed having to wait nearly an hour for an alternative meal of soup was unacceptable.</p> <p>-He stated he was not in charge of alternative meals and the person who oversaw fulfilling alternative meal requests was cook F.</p> <p>Interview on 10/16/24 at 6:29 p.m. with cook F regarding resident 43's soup request revealed:</p> <p>*She stated:</p> <p>-We didn't get it written down and it went out of our brains.</p> <p>-I can get it right away if the aides would come and wait for it.</p> <p>-We could use another person as we only have three people to serve two dining rooms.</p> <p>*She confirmed it was not acceptable to forget an alternative meal request made by a resident.</p> <p>(continued on next page)</p>		

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 10/17/2024
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.			
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/16/24 at 6:35 p.m. with resident 43 while in his room revealed he stated he was tired from attending dialysis that day and wanted to lay down in his bed. His soup was delivered at that time, and he stated it was not hot enough for his liking but he would eat it anyway.</p> <p>Record review of resident 43's electronic medical record (EMR) revealed:</p> <p>*He was admitted on [DATE] following a hospitalization .</p> <p>*He had a Brief Interview of Mental Status (BIMS) score of 15, indicating he was cognitively intact and could make his own decisions.</p> <p>*His relevant diagnoses included end-stage renal disease, dependence on renal dialysis, reduced mobility, weakness, renovascular hypertension, limitation of activities due to disability, atherosclerotic heart disease, hypertensive heart disease, pleural effusion, hypocalcemia, hyperlipidemia, hypomagnesemia, hyperuricemia, non-ST elevation myocardial infarction (NSTEMI), secondary hyperparathyroidism of renal origin, chronic pain, and a stage 4 pressure ulcer of the sacral region.</p> <p>*He was receiving comfort care services (a type of medical treatment that focuses on improving a patient's quality of life and comfort, rather than extending their life, and is often used for patients who are near the end of life).</p> <p>*He was admitted with a renal diet order, but the dietary order was changed to a regular diet on 7/24/24 because he was refusing most of his meals on the renal diet.</p> <p>*He had orders for an Ensure supplement drink once a day, along with Nepro and Prostat supplement drinks which he was refusing. He stated, They taste awful.</p> <p>*He was on a two gram low sodium diet and a 1,200 ml (milliliter) fluid restriction which was being monitored and documented every shift.</p> <p>*His weight would fluctuate daily depending on dialysis but he had remained stable, within five pounds, since his admission.</p> <p>Interview on 10/17/24 at 4:26 p.m. with administrator A regarding resident 43's meal service and food temperatures revealed:</p> <p>*She confirmed the holding temperatures of the foods could have been higher to maintain a more palatable temperature.</p> <p>*She was aware of what had occurred regarding his meal tray deliveries and his request for soup. She stated there needed to be a better way to deliver the meal trays to resident's rooms in a timelier manner.</p> <p>Review of the provider's 2019 Food Temperatures policy revealed:</p> <p>*1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees F (fahrenheit).</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*3. Temperatures should be taken periodically to assure hot foods stay above 135 degrees F .</p> <p>Review of the provider's 2019 In-Room Dining (Room Service) policy revealed:</p> <p>*Procedure:</p> <p>-1. d. Insulated plate covers, coffee pots, mugs and bowls will help maintain food temperatures during delivery. All foods should be covered and delivered as soon as possible after plating to maintain food quality and temperature.</p> <p>-3. h. Hot food must be hot and cold food must be cold (as acceptable to the individual being served).</p> <p>Review of the provider's 2019 Early and Late Meals policy revealed:</p> <p>*Procedure:</p> <p>-3. Upon arrival on the nursing unit, it is the responsibility of the nursing staff to see that the meals are passed and individuals receive assistance as quickly as possible.</p> <p>*Late Trays:</p> <p>-2. After the meal is served, the cook/chef will reserve enough food for the meals that will be served later. Food should be held safely at the proper temperatures.</p> <p>-3. The nursing staff on the unit will prompt [promptly] serve the meal to assure proper food temperatures.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40788</p> <p>Based on observation, interview, and policy review, the provider failed to ensure food items in one of one Bistro refrigerator/freezer and one of one walk-in refrigerator in the kitchen were properly labeled, dated, and/or covered. Findings include:</p> <p>1. Observation on 10/15/24 at 4:50 p.m. in the Bistro kitchenette revealed:</p> <p>*A sign on the refrigerator: This fridge is for resident use only. Anything placed in this fridge for residents needs to be labeled with room number and the date it is placed. Anything in this fridge without a date or label will be thrown out.</p> <p>*Inside of the refrigerator were the following observed food items:</p> <ul style="list-style-type: none"> -Two pieces of pizza in an undated and unlabeled plastic bag. -One unopened container of Yoplait peach yogurt marked with a resident room number and dated 8/9. The best by date on that container was 9/15/24. -Multiple pieces of sliced pepperoni in an undated and unlabeled plastic bag. -Half of a covered chocolate cream pie that was undated and unlabeled. -One unopened container of cottage cheese marked with a best by date of 10/7/24. -One piece of covered cherry pie in an undated and unlabeled plastic dish. -Two ham sandwiches in an undated and unlabeled plastic container. <p>*In the freezer the following food items were observed:</p> <ul style="list-style-type: none"> -A Lean Cuisine chicken parmesan dinner with a best by date of March 2024. -One carton of vanilla ice cream with a best by date of 9/7/24. -An uncovered chocolate Dairy Queen Blizzard cup with a spoon frozen inside of it. <p>Observation on 10/16/24 at 4:45 p.m. of the walk-in refrigerator in the kitchen revealed:</p> <ul style="list-style-type: none"> *Three undated cellophane-wrapped meat and cheese sandwiches. *One stainless steel container covered with torn aluminum foil labeled Beef for sandwich 10/14. <p>Telephone interview on 10/17/24 at 2:00 p.m. with dietary manager E revealed:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*The task of removing outdated food items was just added to kitchen staffs' weekly cleaning checklist.</p> <p>*No food items were to have been placed in any refrigerator or freezer without first properly covering, dating, and labeling that food item.</p> <p>Review of the provider's 2019 Food and Nutrition Services in Healthcare Policy and Procedure Manual revealed:</p> <p>*Food Production and Food Safety:</p> <p>-4.d. Leftovers must be dated, labeled, covered, cooled and stored in a refrigerator.</p>		