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	02/12/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, interview, and policy review, the provider failed to identify, monitor, and implement pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) healing and prevention interventions for one of one sampled resident (3) who developed a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to his buttocks. Findings include:1. Observation on 2/10/26 at 11:09 a.m. of resident 3 in his room revealed:*There was a cushion in his wheelchair seat.*He had an air mattress on his bed.*Resident 3 was sitting in his recliner.*There was no pressure relieving cushion in his recliner.2. Review of resident 3's electronic medical record (EMR) revealed:*He was admitted to the facility from the hospital on 8/14/25.*His 11/21/25 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated his cognition was moderately impaired.*His diagnoses included diabetes (a condition involving disruptions in how the body regulates blood sugar), stage four kidney disease (severe kidney damage) with dependence on renal dialysis (blood is removed, cleaned by a machine, and returned to the body for people with kidney failure), and reduced mobility.*Resident 3's 8/14/25 discharge instructions from the hospital indicated, Wound Care Instructions Wound location: Right buttock:-Cleanse area with mild soap and water.-Apply barrier cream 3-4 times daily and with each incontinence [involuntary urine or bowel leakage] episode.-Cover open areas with Oval Mepilex [a silicone foam wound dressing].-May consider a silicone border dressing in place of the barrier cream as well due to the decrease in wound area.-Offload with repositioning every 2 hours and as needed.-Offload heels by suspending them off mattress with [a] pillow so heels float over [the] edge of [the] pillow.-Waffle cushion to chair and frequent repositioning while in the chair.*His undated baseline care plan (the admission personalized plan that addresses a resident's care needs, goals, and interventions) stated he had wounds on his sacrum (bone directly above the tailbone), left lateral (outside) foot, and the head of his penis.*Resident 3's 8/14/25 admission assessment indicated his skin was intact and his Braden Scale (a tool used to assess the risk of developing pressure ulcers) assessment score indicated he had high risk for developing a pressure ulcer.*Resident 3's 8/25/25 comprehensive care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had a focus area of At risk of alterations in skin integrity with interventions of Provide incontinent care and apply moisture barrier to help protect skin prn [as needed] and Weekly skin assessment per facility policy.-It did not include that resident 3 had an open area to his right buttocks.-It did not include the application of barrier cream 3-4 times daily and with each incontinent episode, to offload with repositioning every 2 hours and as needed, and a waffle cushion to chair and frequent repositioning while in the chair as was indicated in resident 3's hospital discharge instructions.*His 12/22/25 skin assessment stated, right buttock with small abrasion, barrier cream applied. Left buttock with 0.5 cm [centimeter] open area, erythematous [reddened] and bleeding scant amount. Area dressed with a 3 [inch] x3 [inch] Hydrocellular Foam Dressing Silicone Dressing with Border. Patient tolerated well. Notified [licensed practical nurse (LPN) /wound care nurse G].*There were no skin assessments documented between 12/22/25 and 1/1/26.*Resident 3's 1/1/26 skin assessment indicated his left buttock had an facility acquired open wound and his right buttock had an facility acquired abrasion. The wounds were Stable: previously deteriorating wound (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Actual harm Residents Affected - Few	characteristics plateaued.-There were no measurements or a description of those facility acquired wounds.*There was no skin assessment documented on 1/8/26.*Resident 3's 1/15/26 skin assessment indicated his left buttock had a facility acquired open wound and his right buttock had a facility acquired abrasion. The wounds were Improving; overall wound characteristics improved.-There were no measurements or a description of those facility acquired wounds.*Resident 3's 1/22/26 skin assessment indicated his left buttock had a facility acquired open wound and his right buttock had a facility acquired abrasion.-There were no measurements or a description of those facility acquired wounds or whether his wounds were improving, worsening, or remaining stable.*Resident 3's 1/29/26 skin assessment indicated his left buttock a facility acquired open wound and his right buttock had a facility acquired abrasion.-There were no measurements or a description of those facility acquired wounds or whether his wounds were improving, worsening, or remaining stable.*There was no skin assessment documented on 2/5/26.*Resident 3 had a 2/5/26 physician's order for, Rt [right] and Lf [left] buttock apply triad [a zinc-based paste to manage draining wounds such as a pressure ulcer] daily with sactal [sacral] foam dressing [a specially formed dressing to be for the sacrum] applied till [until] healed every day shift.*His 2/10/26 care plan indicated he had a focus area that was initiated on 12/23/25 for wound management with interventions of Evaluate ulcer characteristics, Measure ulcer on at regular intervals, Monitor ulcer for signs of infection, Monitor ulcer for signs of progression or declination, and Notify provider if no signs of improvement on current wound regimen.3. Interview on 2/11/26 at 3:20 p.m. with assistant director of nursing (ADON) C revealed:*There were no measurements or descriptions of resident 3's wounds on his buttocks because they were not considered pressure ulcers, and LPN/wound care nurse G had not seen him during her weekly rounds.*A cushion was placed in his wheelchair on 11/3/25 because he was sliding down in his wheelchair.*His physician was notified of the newly identified wound on his buttock on 12/23/25 at 11:03 a.m.-The notification stated, Resident has abrasion to his RT. and LT buttock due to sliding in W/C [wheelchair].*His air mattress was placed on his bed on 1/27/26 (after the wounds were identified).4. Observation and interview on 2/12/26 at 8:23 a.m. with resident 3 in his room revealed:*He did not know when the cushion was placed on the seat of his wheelchair and he could not recall having a pressure reduction cushion on his recliner.*He was sleeping in his recliner for about the last month because the air mattress on his bed leaked.*When he would sleep on the air mattress it would deflate, and he would end up lying on the frame of the bed.*The air mattress was unplugged at the time of this observation.5. Interview on 2/12/26 at 9:34 a.m. with certified nursing assistant (CNA) O revealed:*She did not know if resident 3 slept in his recliner or bed, but each day when she arrived to work he was dressed and sitting in his recliner or wheelchair.*She did not unplug resident 3's air mattress.*She did not know when the cushion was placed in resident 3's wheelchair.*She acknowledged there was no pressure reduction cushion in resident 3's recliner.*Resident 3's buttocks did not have a wound dressing when she assisted him to the bathroom that morning (2/12/26) but stated some days there was a dressing on his buttocks.*She applied barrier cream to his buttocks each time she changed his brief or assisted him to the toilet because he was incontinent.6. Observation and interview on 2/12/26 at 9:43 a.m. with LPN/wound care nurse G and CNA O during resident 3's skin assessment revealed:*There was no wound dressing on resident 3's buttocks.*He had a six cm by three and one-half cm area on his right buttocks where the first layer of skin was missing and the top of that area had a two cm by three and one-half cm scabbed area. His left buttocks had a three and seven-tenths cm by two cm area where his first layer of skin was missing.*LPN/wound care nurse G stated she did not consider resident 3's wounds on his buttocks pressure ulcers because the skin blanched (the skin turned white when pressure was applied and then returned to pink after the pressure was released).*LPN/wound care nurse O did not apply a dressing to resident 3's buttocks. She rolled him back onto his back, and asked CNA O to assist him out of bed and back into his chair.*LPN/wound nurse care G stated she had worked as an LPN for one year and had completed additional training to be a wound care nurse on (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	10/13/25.*LPN/wound care nurse G did not have a designated registered nurse (RN) who oversaw her wound care role, but she would ask an RN if she had any questions related to a wound.*She monitored surgical wounds, vascular wounds, arterial wounds, and pressure ulcers for residents.*The nurse assigned resident 3 on his bath day was to perform his weekly skin checks and document in his EMR the measurements and descriptions of his wounds.*She acknowledged that resident 3's wounds were not measured or described on his weekly skin assessments.*LPN/wound care nurse G had completed resident 3's admission assessment on 8/14/25.*Within the admission assessment LPN /wound care nurse G had completed a skin assessment and documented that resident 3 did not have skin concerns.*She was not aware that resident 3's baseline care plan indicated he had wounds on his sacrum, left foot, and the head of his penis.*She did not complete resident 3's baseline care plan and did not know who had completed it.*LPN/wound care nurse G acknowledged that the location on resident 3's buttocks was an area that sustained pressure when he was sitting in his recliner and wheelchair.*She was not aware that resident 3 was sleeping in his recliner without pressure reduction cushion.7. Interview and EMR review on 2/12/26 at 11:00 a.m. with RN N revealed:*If a pressure ulcer was identified on a resident, the nurse should document the size and a description of the ulcer in a skin assessment in that resident's EMR and then notify the LPN/wound care nurse G and the physician.*A risk management form was to be completed by the nurse who identified the ulcer to notify management that a pressure ulcer was identified on a resident.*RN N would measure and document a resident's pressure ulcer in a skin assessment in that resident's EMR when it was initially identified or if she thought the pressure ulcer was increasing in size or getting worse.*LPN/wound care nurse G measured and documented the resident's pressure ulcers weekly in a skin assessment.*RN N had completed resident 3's wound care treatment to his buttocks that morning (2/12/26).*She did not put a dressing on his buttocks because the physician's order was for triad paste to his buttocks.*Upon review of resident 3's treatment order for his buttocks she verified the physician's order for resident 3's wound care treatment on his buttocks was to use triad paste and cover it with a foam dressing.-She stated she did not apply the foam dressing over the triad paste because the previous order did not have that on it, and she did not read the entire order before she completed his treatment that day.*RN N stated resident 3 had an ongoing issue with skin breakdown on his buttocks.*When asked what her assessment of resident 3's buttocks wound was that morning she stated he had a stage II pressure ulcer.*He was not sleeping in his bed for at least the past week. There was one night he slept in his wheelchair all night, so an air mattress was placed on his bed. She thought after that he was sleeping in his bed because the night shift nurses did not report anything different.*When she arrived at the facility to work her morning shift, he was in his wheelchair or recliner ready to go to dialysis.8. Interview on 2/12/26 at 12:11 p.m. with ADON C revealed:*ADON C was an LPN.*The CNAs were to observe each resident's skin daily and report any abnormalities to the nurse.*The nurse was to check the resident's skin and document their observation in the resident's EMR weekly on their scheduled bath day.*If the nurse observed a wound on a resident's, ADON C expected the nurse to measure the wound and then document it in the resident's EMR with a description of the wound, such as drainage and what the wound bed looked like. The nurse would then notify the resident's primary care provider.*The nurse who identified the wound was to notify LPN/ wound care nurse G to assess the resident's wound.*If LPN/wound care nurse G determined the wound was not a pressure ulcer, venous ulcer, arterial ulcer, or surgical wound she would refer the wound back to the nurses to manage the assessments and treatments of that wound.*The nurses would then be responsible for completing an alert progress note in the resident's EMR related to that wound two times a day until the wound was healed to track the progress of the wound.-ADON C acknowledged that there were no alert progress notes in resident 3's EMR related to his 12/22/25 wounds.*If the nurses felt a resident's wound had increased in size or worsened ADON C expected the nurses to notify LPN/wound care nurse G so she could reevaluate the wound.-ADON C stated there was no documentation that the nurses had notified LPN/wound care (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	nurse G that there was an increase in the size of resident 3's wounds on his buttocks.*She expected the nurses to follow the physician's orders for the treatment of a wound.*Residents with pressure ulcers were reviewed during the provider's weekly nutrition and wound committee meetings (an interdisciplinary team meeting to discuss residents who had nutritional risks or had wounds, and to discuss possible interventions for those nutritional risks or wounds).-Resident 3 was not reviewed related to his wounds on his buttocks because they were not identified as pressure ulcers, but he was reviewed because he received dialysis.*Resident 3 had a cushion in his wheelchair before his wounds on his buttocks were identified on 12/22/25.*There was no documentation to support resident 3 having a pressure reduction cushion in his recliner.*His air mattress was placed on his bed after resident's 3's wounds on his buttocks were identified on 12/22/25 because he had stated his other mattress was too hard.*ADON C stated resident 3 had told her he did not use a cushion in his dialysis chair, which he sat in for several hours at a time three days a week, but she did not confirm that with the dialysis staff.*She acknowledged that resident 3's 8/14/25 hospital discharge instructions indicated that resident 3 had a wound on his right buttocks with orders to clean and apply a dressing over the wound, apply barrier cream, place a waffle cushion in resident 3's chair and to reposition him frequently while he was in the chair.*She acknowledged resident 3's undated baseline care plan indicated he had wounds on his sacrum, left foot, and the head of his penis but his 8/14/25 admission assessment indicated he did not have any wounds.*She acknowledged there were missing weekly skin checks in resident 3's EMR.*She acknowledged that it could not be determined if resident 3's wounds to his left and right buttocks were improving or worsening, because there were no weekly measurements or descriptions of his wounds.*She acknowledged that resident 3's care plan did not contain pressure reduction measures such as his wheelchair cushion, air mattress, or other preventative pressure reduction measures.9. The director of nursing (DON) was not in the facility or available for interview during the survey.10. Review of the provider's 6/9/25 Pressure Injury Prevention and Management policy revealed:*The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.*Examples of risk factors [for pressure injury risk] include, but are not limited to:- Impaired/decreased mobility and decreased functional ability:- Co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus;- Drugs such as steroids that may affect healing;- Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency;- Resident refusal of some aspects of care and treatment;- Resident refusal of some aspects of care and treatment;- Cognitive impairment;- Exposure of skin to urinary and fecal incontinence;- Under nutrition, malnutrition, and hydration deficits; and- The presence of a previously healed pressure injury.*Evidence-based interventions for prevention [of pressure ulcers] will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions include, but are not limited to:- Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc);- Minimize exposure to moisture and keep skin clean, especially of fecal contamination;- Provide appropriate, pressure-redistributing, support surfaces;- Provide non-irritating surfaces; and- Maintain or improve nutrition and hydration status, where feasible.*Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate (if present), presence of pain, signs of infection, wound bed, wound edge and surrounding tissue characteristics.*Nurse Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance and document a summary as applicable.*Nurse Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance and document a summary as applicable.- The presence of a new pressure injury upon identification.- The progression towards healing, or lack of healing, of any pressure injuries.Review of the provider's (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	6/10/25 Skin Assessment policy revealed:*A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter.*Documentation of skin assessment:- Include date and time of the assessment, your name, and position title.- Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.)- Document wound.- Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain).- Document if resident refused assessment and why.- Document other information as indicated or appropriate.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on Payroll Based Journal (PBJ) reports, interview, schedule review, and facility assessment review, the provider failed to ensure a registered nurse (RN) was scheduled for eight consecutive hours of coverage for six days in quarter four (July 1 through September 30) of fiscal year 2025 and for two of fourteen days (1/29/26 and 1/31/26) between 1/28/26 and 2/10/26. Findings include:1. Review of the PBJ report for quarter 4 of fiscal year 2025 revealed the provider did not have RN coverage for eight consecutive hours on 7/4/25, 7/19/25, 7/26/25, 7/27/25, 8/30/25, and 8/31/25.2. Interview on 2/10/326 at 8:30 a.m. with administrator A during the entrance conference revealed the provider did not have any nurse staffing waivers.3. Interview on 2/12/26 at 8:37 a.m. with administrator A revealed there were not eight consecutive hours of RN coverage on 7/4/25, 7/19/25, 7/26/25, and 7/27/25.*An RN had not been scheduled to work on 7/4/25, 7/19/25, 7/26/25, and 7/27/25.4. Interview on 2/12/26 at 10:51 a.m. with assistant director of nursing (ADON) C revealed:*There were not eight consecutive hours of RN coverage on 8/30/25 and 8/31/25.*An RN had not been scheduled to work on 8/30/25 and 8/31/25.*Recently the provider had made the daily eight consecutive hours of RN coverage a focus area for the facility and two RNs were hired to help cover those hours on 12/8/25 and 2/3/26.5. Review of the nursing schedule from 1/28/26 through 2/11/26 revealed:*On 1/29/26 RN U was scheduled from 8:30 a.m. until 11:30 a.m. and director of nursing (DON) B was scheduled 2:00 p.m. until 7:00 p.m.-These hours did not satisfy the requirement of eight consecutive hours of RN coverage.*On 1/31/26 DON B was scheduled from 9:00 a.m. until 1:00 p.m.-These hours did not satisfy the requirement of eight consecutive hours of RN coverage.6. The director of nursing (DON) was not in the facility or available for an interview during the survey.7. Review of the provider's 9/22/25 Facility Assessment Tool revealed 2-6 floor direct care RN/LPN [licensed practical nurse] per day (at least 1 RN daily, may include MDS [Minimum Data Set] for RN needs, and nurses working on medication carts).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure infection control practices were followed regarding the storage of oxygen equipment for four of four sampled residents (1,18, 49, and 69) who required the use of oxygen. Findings included: Observation and interview on 2/10/26 at 10:02 a.m. with resident 1 in his room revealed: *He was lying in bed with his nasal cannula on which was connected to his oxygen concentrator (a device that filter room air into purified oxygen) beside him. *His wheelchair was positioned next to his bed and had a portable oxygen tank hanging on the back. There waws a nasal cannula connected to the oxygen tank that was laying on the floor underneath the wheel of the wheelchair. *The resident stated that the staff assisted him with removing and reapplying his nasal cannula. 2. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted to the facility on [DATE]. *His 12/15/25 Brief Interview of Mental Status (BIMS) assessment score was 12, which indicated his cognition was moderately impaired. *His diagnoses included chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia (where tissues are deprived of adequate oxygen), adult failure to thrive, hypotension (low blood pressure), cachexia (irreversible metabolic syndrome, severe loss of skeletal muscle mass and body fat, resulting in extreme weakness), and ischemia cardiomyopathy (the heart muscles become weakened and cannot pump blood efficiently). *He had a 1/16/26 physician's order, Oxygen: Oxygen at 1-5 L [liter] per NC [nasal canula] every shift for oxygen use. 3. Observation on 2/10/26 at 10:15 a.m. of resident 18's room revealed: *Resident 18 was lying in bed with a nasal cannula on that was attached to her oxygen concentrator. *On the back of resident 18's wheelchair was a portable oxygen tank. *Attached to the portable oxygen tank was a nasal cannula that was draped over the back of the wheelchair and lying on resident 18's wheelchair seat that had dry white flakes on the cushion. 4. Observation on 2/10/26 at 10:20 a.m. of resident 69's room revealed: *Resident 69 was not in her room. *There was an oxygen concentrator (a device that filters room air into purified oxygen) by the wall with a nasal cannula coiled up and placed under the handle of the oxygen concentrator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Observation on 2/10/26 at 2:04 p.m. of resident 69's room revealed: *She was lying in bed wearing a nasal cannula that was attached to her oxygen concentrator. *The nasal cannula attached to her portable oxygen tank on the back of her wheelchair was hanging on the handle of resident 69's wheelchair. *The portion of the nasal cannula that would be put into resident 69's nose was in touching the handle of the wheelchair where someone's hands would be placed to push the wheelchair. 6. Observation on 2/10/26 at 2:50 p.m. in resident 49's room revealed: *He was sitting in his recliner with his feet elevated. *His wheelchair was next to his bed, and it had a portable oxygen tank on the back of it. *The nasal cannula attached to the portable tank was draped over the back of the wheelchair and rested on the wheel of the wheelchair. 7. Observation on 2/10/26 at 4:45 p.m. of resident 18's room revealed: *Resident 18 was not in her room. *Her oxygen concentrator was on, and the attached nasal cannula was draped over the head of resident 18's unmade bed. 8. Observation on 2/11/25 at 3:27 p.m. of resident 18's room revealed: *Resident 18 was not in her room. *Her oxygen concentrator was on, and the attached nasal cannula was hanging on the siderail (bar/bars attached to the bed) attached to the head of her bed and the prongs that are placed in [NAME] resident's nose were lying against the base of the side rail and mattress. 9. Interview on 2/11/26 at 2:01 p.m. with certified nursing assistant (CNA) O revealed: *Resident 18 required staff assistance to switch between using her oxygen concentrator in her room and her portable oxygen tank on her wheelchair. *Resident 69 required staff assistance to switch between using her oxygen concentrator in her room and her portable oxygen tank on her wheelchair. *Nasal cannulas were to be stored in plastic bags and attached to the oxygen concentrator or portable oxygen tank when they were not being used by the residents. *She acknowledged that the residents' nasal cannulas were not stored in plastic bags on 2/10/26 because there were no plastic bags on the residents' oxygen concentrators or portable oxygen tanks. She tried to store them in places where they were not at risk of touching the floor. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She had asked for plastic bags to hang on the residents' oxygen concentrators and portable oxygen tanks on 2/10/26, but the plastic bags were not brought to her from supply. 10. Observation on 2/12/26 at 9:36 a.m. in resident 49's room revealed: *He was not in his room. *There was an oxygen concentrator in his room with a nasal canula connected to it, and the nasal canula was lying on the floor. 11. The director of nursing (DON) was not in the building and was not available for interview. 12. Interview on 2/12/26 at 9:41 a.m. with assistant director of nursing (ADON) C revealed: *When a resident was admitted to the facility and required oxygen the admitting nurse was responsible for obtaining a storage bag and placing the resident's nasal cannula in the bag. *The staff were expected to use the bag to store the nasal cannula when it was not in use. *If the residents did not have a storage bag, the staff were responsible for obtaining one for the residents. 13. Review of the provider's 5/16/25 Oxygen Administration policy revealed: *Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. *Keep delivery devices covered in a plastic bag when not in use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure the resident's medications were labeled and discarded for: Two of two sampled residents (7 and 18) who had opened boxes of nasal spray (Flonase) which that were not kept available for use after their use-by date. Two of two sampled residents (18 and 62) whose pain medications (hydrocodone and oxycodone) were not labeled according to their physician's order. One of one sampled resident's (15) inhaler that was expired and was not stored in a secure location. Findings include:1. Observation and interview on 2/10/26 at 10:15 a.m. of the 400 hall medication cart with certified medication aide (CMA) K revealed: *There were two opened boxes of residents' Flonase nasal sprays. *Resident 7's nasal spray had a use-by date of 6/25/25, and resident 18's nasal spray had a use-by date of 12/29/25. *CMA K stated that nasal sprays were labeled with use-by dates, and the staff were expected to review those dates before administering the spray. Those expired nasal sprays should have been discarded by the staff. *Review of residents 7 and 18's medication administration records (MAR) revealed both residents had orders for PRN (as needed) Flonase. 2. Observation, interview and medication administration record (MAR) review on 2/10/26 at 12:10 p.m. with CMA K who was preparing resident 18's medications for administration revealed: *The resident's hydrocodone blister pack (a hand-held card from which individual pills or capsules are dispensed into medication cups for administration) label indicated one pill was to be administered every four hours PRN. *The resident's MAR indicated one pill was administered four times daily. CMA K then administered one hydrocodone pill to the resident. *CMA K knew she was expected to compare the resident's blister pack label to the resident's MAR order for any discrepancies between the two before she administered the hydrocodone pill. She did not do that. 3. Observation, interview and MAR review on 2/11/26 at 11:40 a.m. with CMA L who was preparing resident 62's medications for administration revealed: *The resident's oxycodone blister pack label indicated one 5 mg (milligram) pill was to be administered three times daily and another 5 mg pill was to be administered one time daily PRN. *The resident's MAR indicated that one 5 mg oxycodone pill was administered four times daily. There was a second, separate order on that MAR for one 5 mg pill to be administered one time daily PRN. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*CMA L recognized the discrepancy between the resident's blister pack label and the resident's MAR order. She knew the resident's MAR was updated on 1/30/26 to reflect four scheduled oxycodone administrations (8:00 a.m., noon, 4:00 p.m., and 8:00 p.m.). She thought there should have been a change order sticker affixed to the resident's blister pack to alert staff to the updated oxycodone order. 4. Interview on 2/11/26 at 4:45 p.m. with assistant director of nursing (ADON) C regarding medication labeling revealed: *That a resident's blister pack label was expected to be compared to their MAR for any discrepancy by the staff before administering that medication. Any discrepancy was expected to be brought to her attention or to another licensed nurse for follow-up. *The licensed nurse was responsible for affixing any change order stickers to the blister pack based on order changes and for notifying the pharmacy of the blister pack label discrepancy. 5. Review of the provider's revised 5/7/25 Medication Administration policy revealed: 11. Review MAR to identify medication to be administered. 12. Compare medication source (bubble [blister] pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, routine, and time. There was no indication of what process to follow if a discrepancy was found between the medication source and the MAR. Review of the provider's revised 5/16/25 Labeling of Medications and Biologicals policy revealed 12. The pharmacy must be informed of any order changes or changes in directions for the use of the medication. 6. Observation on 2/10/26 at 10:55 a.m. of resident 16's room revealed he had an inhaler lying on his bedside table. 7. Observation and interview on 2/11/26 at 8:31 a.m. with resident 16 in his room revealed: *The inhaler on his bedside table was albuterol (a medication used to treat shortness of breath or wheezing) 90 mcg (micrograms) per inhalation. -It expired on 6/30/23. *Resident 16 stated he did not use an inhaler but his roommate resident 15 did. *He did not know if resident 15 had recently used that inhaler. *He stated a nurse had brought the inhaler into his room, set it on his bedside table, and then left the room and never came back to get it. 8. Review of resident 16's EMR revealed he did not have a physician's order for an inhaler or for the self-administration of medications. 9. Review of resident 15's EMR revealed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She was admitted to the facility on [DATE]. *Her 1/28/26 BIMS assessment score was 8, which indicated her cognition was moderately impaired. *She had a 9/18/25 physician's order for Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT [micrograms per actuation (per puff)] 4 puff inhale orally every 4 hours as needed for wheezing. *She did not have a physician's order to have medications stored at her bedside. 10. Interview on 2/11/26 at 11:09 a.m. with resident 15 revealed she did not know if she had used the inhaler that was on resident 16's bedside table. 11. Interview on 2/11/26 at 2:10 p.m. with CMA K revealed: *She was not aware there was an inhaler on resident 16's bedside table. *He did not have a physician's order for an inhaler but his roommate resident 15 did. *She stated that there should not be any medications stored in that room. *If she had seen the inhaler she would have brought it to the nurse. 12. Interview on 2/12/26 at 11:58 a.m. with RN N revealed: *The nurse who worked the during the night shift was supposed to check the medication room and the medication carts for expired medications monthly. *An inhaler was not to be left in a resident's room unless there was a physician's order and an assessment was completed to determine if a resident was able to safely self-administer their own medications. *She expected the staff to bring any medications found in a resident's room to the nurse. *She stated resident 15 would not be able to safely self-administer her medications. 13. Interview on 2/12/26 at 12:11 p.m. with ADON C revealed: *Medications were not to be stored in a resident's room without a physician's order and an assessment completed for the self-administration of medications. *She expected the staff to bring any medications found in a resident's room to the nurse. *Resident 15 would not be able to safely self-administer her medications. *Expired medications were not to be administered to the residents. *The medication room and medication carts were to be checked monthly for outdated medications by the director of nursing (DON), ADON, and the CMAs and then destroyed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The provider's consultant pharmacist checked the medication room and medications carts for expired medications and to be sure items were stored according to the manufacturer's instructions and compliant with the state and federal regulations.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed infection prevention and control practices regarding:*Hand hygiene (handwashing) by two of two certified medication aides (CMA) (K and L) during medication administration for three of three sampled residents (46, 55 and 65).*An indwelling urinary catheter (flexible tubing inserted into the bladder to drain urine) being kept off the floor for one of one sampled residents (49).*The use of enhanced barrier precautions (EBP), glove and gown use when providing contact care, by the staff for three of three residents (3, 7, and 9) who were on enhanced barrier precautions (EBP), and one of one sampled resident (3) who was transferred by two of two staff members (certified nursing assistant (CNA) O and care assistant W) without using EBP.Findings include:1. Observation and interview on 2/10/26 at 1:45 p.m. with CMA K revealed: *She had prepared resident 55's nebulizer (a device that converts liquid medications into inhalable mist) treatment after using her laptop computer to check the nebulizer order, she retrieved the nebulizer medication from inside the medication cart. *She entered resident 55's's room, and without first performing hand hygiene, she assembled the nebulizer tubing, nebulizer medication cup, and mask. *She placed the medication into the nebulizer cup and turned on the nebulizer machine. CMA K then put the nebulizer mask over the resident's nose and mouth and ensured the elastic band attached to the mask was placed behind the back of the resident's head to keep the mask in place. *CMA K stated she would return to the resident's room in 10 minutes to remove the mask from the resident's face, turn off the machine, and clean the nebulizer equipment. *After she exited resident 55's room, CMA K returned to the medication cart, and without performing hand hygiene, she prepared resident 46's medications for administration. *Following the above observation, CMA K acknowledged she should have performed hand hygiene upon entering resident 55's room before she handled the resident's nebulizer equipment and medication. *She agreed that after exiting resident 55's room, she should have but did not perform hand hygiene before she prepared resident 46's medications for administration. 2. Observation and interview on 2/11/26 at 8:00 a.m. with CMA L revealed: *That without first performing hand hygiene, she prepared resident 65's medications for administration to the resident. *After those medications were administered, CMA L performed hand hygiene. *CMA L stated it was expected that hand hygiene was performed both before and after medication administration for each resident. 3. Interview on 2/11/26 at 5:00 p.m. with assistant director of nursing (ADON) C regarding infection (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevention and control practices revealed: *That hand hygiene was expected to be performed by all caregivers before and after all transitions in residents' care performed. *She confirmed that was not demonstrated by CMAs K and L in the above observation but it should have been. 4. Review of the provider's revised 5/15/25 Nebulizer Therapy policy revealed: 2. Gather appropriate equipment and ordered medication. 4. Perform hand hygiene. 5. Review of the provider's revised 5/7/25 Medication Administration policy revealed: 4. Perform hand hygiene prior to administering medication per facility protocol and product. 18. Observe resident consumption of medication. 19. Wash hands using facility protocol and product. 6. Observation and interview on 2/10/26 at 2:50 p.m. with resident 49 in his room revealed: *He was sitting in his recliner with his feet elevated. *He stated that he was unable to transfer from his wheelchair to his recliner without the staff's assistance. *He had a urinary catheter, and the drainage bag was lying directly on the floor. *There was no dignity bag (a specialized cover to conceal urinary drainage bags from the public view) or other cover around the drainage bag. There was no barrier between the drainage bag and the floor to protect it from potential contamination. *He said he did not put the drainage bag on the floor, and then said, I guess they [staff] put it on the floor when they got me in my chair. 7. Observation and interview on 2/11/26 at 10:30 a.m. with resident 49 in his room revealed: *He was sitting in his recliner with his feet elevated. *His catheter drainage bag was lying directly on the floor without a cover or a protective barrier. *He did not remember which staff member helped him get into his recliner that morning. 8. Observation and interview on 2/11/26 at 4:16 p.m. with CNAs P and Q in resident 49's room revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Resident 49 was in his recliner with his feet elevated. *The catheter drainage bag was hanging on the elevated footrest of the recliner. *Neither CNA P or Q had hung the drainage bag on the recliner's footrest. *When asked about the previous observation of the drainage bag lying on the floor, both CNAs P and Q said that the drainage bag should not be lying directly on the floor. CNA Q stated, That is unacceptable, and indicated there should be a barrier between the drainage bag and the floor to prevent potential contamination. 9. Interview on 2/12/26 at 10:09 a.m. with assistant director of nursing (ADON) C revealed: *Their policy was to place a resident's catheter drainage bag into a dignity bag. *She expected the staff to secure the dignity bag to the resident's bed when a resident was resting in a recliner or bed. *The catheter drainage bags were not be directly on the floor due to infection control concerns. 10. Review of the provider's 6/6/25 Indwelling Catheter Use and Removal policy revealed: *Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures. *Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodgement of the catheter; *Securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioning below the level of the bladder. 11. Review of the provider's 5/2/25 Catheter Care policy revealed: *Privacy bags will be available and catheter drainage bags will be covered at all times while in use. 12. Review of the provider's undated Catheter Care Competency Assessment revealed: *The purpose of this procedure is to prevent catheter-associated urinary tract infections. *Infection Control -Be sure the catheter tubing and drainage bag are kept off the floor. 13. Observation and interview on 2/10/26 at 2:44 p.m. with resident 9 in her room revealed: *There was no personal protective equipment (PPE), which would include a gown or gloves, or sign on resident 9's door indicating she was on EBPs. *Resident 9 stated the staff did not wear a gown or gloves when they assisted her with toileting, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	getting dressed or transferring her. 14. Review of resident 9's electronic medical record (EMR) revealed: *She was admitted to the facility on [DATE]. *Her 12/17/25 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. *She had a 12/19/25 physician's order for Enhanced Barrier Precautions r/t [related to] MDRO [multi drug resistant organism (an organism that is resistant to most antibiotics)]: Hx [history] of E. coli [Escherichia coli (a bacteria that lives in the intestine, with some strains of these bacteria causing diarrhea, urinary tract infections, and pneumonia)] per standing orders. *Her 2/10/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated Enhanced barrier precautions r/t infection or colonization with CDC [Center for Disease Control] -targeted MDRO initiated on 12/19/25. -Gown and gloves [were to be worn by staff] during high-contact personal care activities. 15. Observation on 2/10/26 at 4:39 p.m. revealed there was no PPE or an EBP sign on resident 3's door to indicate he was on EBP. 16. Observation on 2/11/26 at 8:24 a.m. of resident 3 in his room revealed: *CNA O and care assistant W transferred resident 3, using a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) from his wheelchair to the toilet. *CNA O and care assistant W were not wearing PPE. 17. Observation and interview on 2/11/26 at 3:24 p.m. with resident 3 in his room revealed: *He had a dialysis port in his right upper chest. *Resident 3 stated the staff did not wear a gown or gloves when they assisted him to the toilet, getting dressed, or transferred him. 18. Review of resident 3's EMR revealed: *He was admitted to the facility on [DATE]. *His 11/21/25 BIMS assessment score was 10, which indicated his cognition was moderately impaired. *He had a 11/19/25 physician's order for Enhanced Barrier Precautions d/t [due to] dialysis port [a surgically implanted catheter that allows blood to be removed, cleaned by a machine, and returned to the body for people with kidney failure]. *His 2/10/26 care plan stated, Enhanced barrier precautions d/t dialysis port initiated on 11/19/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	19. Observation and interview on 2/11/26 at 10:04 a.m. with resident 7 in her room revealed: *There was no PPE or EBP sign on resident 7's door that indicated she was on EBP. *Resident 7 stated the staff did not wear a gown or gloves when they assisted her with toileting, bathing, or getting dressed. 20. Review of resident 7's EMR revealed: *She was admitted to the facility on [DATE]. *Her 12/22/25 BIMS assessment score was 10, which indicated her cognition was moderately impaired. *She had a 2/27/25 physician's order for Enhanced Barrier Precautions r/t MDRO. *Her 2/10/26 care plan stated, Enhanced barrier precautions r/t infection or colonization with CDC-targeted MDRO SPECIFY: hx of ESBL [Extended-spectrum beta-lactamase (an enzyme produced by bacteria that makes the resistant to many antibiotics)] (1/2/2020) initiated on 11/18/24. -Don [put on] gown and gloves during high-contact personal care activities. 21. Review of the provider's undated resident care sheet (an abbreviated resource for staff members to refer to when providing resident care) revealed: *Resident 3 was not indicated as being on EBP. *Resident 7 was indicated to require EBP due to a wound and a line (an intravenous line, a feeding tube, or a dialysis port). *Resident 9 was indicated to require EBP due to an MDRO. 22. Interview on 12/11/26 at 2:01 p.m. with CNA O revealed: *She would know if a resident was on EBP if there was PPE and an EBP sign hanging on the outside of the door. *Residents 3 and 7 were not on EBP because there was no PPE or an EBP sign hanging on the outside of their rooms that indicated they were on EBP. *Resident 3 was admitted to the facility with a dialysis access port. *CNA O stated resident 3 probably should have been on EBP, since his admission, due to his dialysis access port. 23. Interview on 2/12/26 at 12:11 p.m. with ADON C revealed: *The staff knew a resident was on EBP when there was PPE and an EBP sign hanging on the outside of the resident's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The residents were to be on EBP if they had a urinary catheter, a feeding tube, a wound, a history of or a current MDRO, or a dialysis access port. *A gown and a pair of gloves were to be worn anytime the staff provided direct care for residents on EBP. *Resident 3 had a dialysis access port when he was admitted to the facility. *Resident 3 was supposed to be on EBP, but when he moved rooms, his EBP sign and PPE must not have moved with him. *Resident 7 was to be on EBP for her history of ESBL in her urine. *She was not aware that resident 7 did not have PPE or an EBP sign on her door to indicate to the staff that she was on EBP. *On 12/19/25 medical director V ordered resident 9 to be on EBP, ADON C stated she did not know why he had written that order. *She was not aware resident 9 did not have PPE or an EBP sign on her door. 24. The director of nursing (DON) was not in the facility or available for an interview during the survey. 25. Review of the provider's 4/11/25 Enhanced Barrier Precautions (EBP) policy revealed: *'Enhanced barrier precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employes targeted gown and gloves during high contact resident care activities. *The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-[contact resident care activities.] *The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC but may be considered epidemiologically important. *Implementation of Enhanced Barrier Precautions: -Make gown and gloves available immediately near or outside of the resident's room. -Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). -The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. *High -contact resident care activities include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dressing[.] -Bathing[.] -Transferring[.] -Providing hygiene[.] -Changing linens[.] -Changing briefs or assisting with toileting[.] -Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC [peripherally inserted central catheter] lines, midline catheters[.] -Wound care: any skin opening requiring a dressing[.]

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, manufacturer's recommendations for use, and policy review, the provider failed to ensure residents were evaluated for the ability to safely administer their medications or had a physicians order for two of two sampled residents (55 and 65) who were observed self-administering their medications and for 0ne of one sampled resident (62) observed with a medication left at her bedside by one of one certified medication aide (CMA) (M). Findings include: 1.Observation and interview on 2/10/26 at 1:45 p.m. with CMA K in resident 55's room revealed CMA K administered resident 55's nebulizer (a device that converts liquid medication it an inhalable mist) treatment. After placing the nebulizer medication inside the medication cup, CMA K attached the face mask to the medication cup and secured the nebulizer mask over resident 55's nose and mouth. CMA K started the nebulizer machine, and turned the machine on to start the treatment. CMA K stated she would return to the resident's room in 10 to 15 minutes when the treatment was completed which was CMA K's usual practice. Observation and interview on 2/10/25 at 2:40 p.m. with CMA K revealed she returned to resident 55's room to turn off the nebulizer machine, remove and clean the face mask. CMA K had spaced it [forgotten] and dd not return to resident 55's room [ROOM NUMBER]-15 minutes after she had started the treatment. Review of resident 55's electronic medical record (EMR) revealed her Brief Interview for Mental Status (BIMS) assessment score was six. That indicated the resident had severe cognitive impairment. She had a medication self-administration assessment completed on 6/9/25. It indicated the resident was safe for neb [nebulizer] self administer [self-administration] after [the nebulizer was] set up [by staff.] Staff will return to monitor usage and shut off [the] machine. There was no physician's order that indicated resident 55 was safe to self-administer her nebulizer treatment. 2. Observation on 2/11/26 at 8:00 a.m. of CMA L administering resident 65's inhaler revealed CMA L turned the base of the inhaler until it clicked, opened the inhaler cap and handed it to the resident. The resident shook the inhaler, placed her lips around the mouthpiece and dispensed one puff into her mouth. She opened her mouth after she took that puff, and the inhaled medication drifted out of her mouth. The resident self-administered the second puff from the inhaler in the same manner. Interview on 2/11/26 at 8:05 a.m. with CMA L regarding resident 65's inhaler self-administration revealed she knew the resident did not properly self-administer the inhaler. She thought the resident would have been able to correctly self-administer the inhaler with verbal instruction, but CMA L did not provide that instruction to the resident. Review of resident 65's EMR revealed she was admitted to the facility on [DATE]. Her BIMS assessment score was 15. That indicated the resident's cognition was not impaired. She was not assessed to determine her ability to safely self-administer her inhaler. There was no physician's order that indicated the resident was safe to self-administer her inhaler. Review of the manufacturer's instructions for use of the Stiolto respimat inhaler revealed: 3. Exhale: Breath out fully, away from the inhaler.4. Inhale: Seal lips around the mouthpiece, avoiding covering the air vents. While taking a slow, deep breath, press the dose-release button.5. Hold: Continue breathing in and hold breath 5-10 seconds. 3. Observation and interview on 2/11/26 at 11:40 a.m. with resident 62 while CMA L administered her medications revealed that on top of her over-the-bed table, there was a clear plastic cup with an amber colored liquid in it. The resident stated that the cup contained a get well soon medication. She was not able to remember who had given her that cup or how long the cup had been there. CMA L removed the cup from the resident's room after she administered the resident's medications. Interview on 2/11/26 at 11:45 a.m. with CMA L revealed she thought the liquid inside the cup removed from resident 62's room was Prostat, a physician-ordered nutritional supplement that was administered to the resident each morning. CMA L had administered the resident's scheduled Prostat earlier that morning. Review of resident 62's EMR revealed she was admitted to the facility on [DATE]. Her BIMS assessment score was 11. That indicated resident 62 had moderate cognitive (continued on next page)

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	435035	A. Building B. Wing	02/12/2026

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impairment. A medication self-administration assessment was not completed with the resident. There was a physician's order for one ounce of Prostat to be administered each morning to promote wound healing. That order did not indicate that the Prostat was able to be left at the resident's bedside. 4. Interview and EMR review on 2/11/26 at 10:00 a.m. and at 12:10 p.m. with assistant director of nursing (ADON) C revealed that resident 55's medication self-administration assessment was not current and was to be updated quarterly, but that did not occur. Resident 55 did not have a physician's order to self-administer her nebulizer treatment, but she should have. CMA K should not have left resident 55 unattended during her nebulizer administration. There was no medication self-administration assessment or a physician's order that supported resident 65's ability to self-administer her inhaler. She expected CMA L not have allowed resident 55 to self-administer her inhaler.Regarding resident 62's Prostat, ADON C had determined that on the morning of 2/10/26, CMA M had left resident 62's Prostat on her over-the-bed table without confirming if she was safe to self-administer that medication. There was no medication self-administration assessment or a physician's order that supported resident 62's ability to self-administer her Prostat. She expected CMA M to not have left resident 55's Prostat on her over-the-bed table without confirming she had consumed it. ADON C was responsible for ensuring medication self-administration assessments were completed for appropriate residents upon a resident's admission to the facility, quarterly, and with a significant change in the resident's condition. ADON C was responsible for ensuring there was a physician's order for a resident to self-administer a medication. 5. Review of the provider's revised 5/16/25 Resident Self-Administration of Medications policy revealed A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely and has a provider order to do so. 4. A self-administration of medication assessment will be completed to determine if a resident is safe to self-administer medications prior to allowing them to do so.16. A re-assessment for safety at a minimum should be considered by the interdisciplinary team for the following: a. Significant change in resident's status. b. Medication errors occur. c. Quarterly.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure a resident's advance directives (a legal document that expresses a person's health care wishes if they become unable to speak for themselves)/code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) was accurately documented for staff to implement the resident's chosen wishes for one of one sampled resident (20) with documented code status discrepancies.Findings include: 1. Review of resident 20's electronic medical record (EMR) revealed:*She was admitted to the facility on [DATE].*Her [DATE] Brief Interview for Mental Status (BIMS) assessment score was 7, which indicated her cognition was severely impaired.*There was a banner displayed in her EMR, which indicated that she did not want CPR (cardiopulmonary resuscitation, an emergency procedure to provide chest compression and often rescue breathing to preserve brain function and maintain blood circulation).*Her care plan had a [DATE] initiated advance directive focus area that indicated I have a DNR [do not resuscitate] order.*There was a [DATE] physician's order for DNR.*Her signed [DATE] advance directive indicated that she wanted CPR/Full resuscitative measures. 2. Interview on [DATE] at 2:45 p.m. with social services director (SSD) R revealed:*She was responsible for obtaining the residents' advance directives when they were admitted to the facility, and advance directives were reviewed periodically during care conferences.*She acknowledged that resident 20's code status did not match her advance directive.*She acknowledged that resident 20 had a physician's order for DNR that did not match her advance directive for over four years.*She did not have an explanation for how this occurred. 3. Observation and interview on [DATE] at 12:18 p.m. with certified nursing assistant (CNA) T revealed:*There was a cheat sheet that listed all the residents in each hall. It had information about how to care for each resident, including the resident's code status, how they were able to transfer, their scheduled bath days, and which dining room they ate in.-Resident 20 was listed as having a DNR code status on that sheet.*He stated there was another way to know a resident's code status, and that was by looking at the icons posted next to the residents' name plates outside of their room door. There would either be a heart icon (indicating a CPR code status) or a flower icon (indicating a DNR code status).-Resident 20 had a flower icon next to her nameplate. 4. Review of the provider's [DATE] Residents' Rights Regarding Treatment and Advance Directives policy revealed:* On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive.* Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to staff.* During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes to any advance directives.* Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions.* Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure the resident's baseline care plan was reviewed with the resident or the resident's representative within 48 hours of the resident's admission to the facility for three of six newly admitted sampled residents (3, 61, and 69). 1. Review of resident 3's electronic medical record (EMR) revealed: *He was admitted to the facility on [DATE]. *His baseline care plan scanned into his EMR on 9/22/25 and was not dated or signed by the staff member who completed it. *There was no signature from resident 3 or their representative to indicate resident 3's baseline care plan was reviewed with them. 2. Review of resident 69's EMR revealed: *She was admitted to the facility on [DATE]. *Her 1/30/26 baseline care plan signed by LPN/wound care nurse G. *There was no signature from resident 69 or their resident representative to indicate resident 69's baseline care plan was reviewed with them. 3. Interview on 2/11/2026 at 3:00 p.m. with ADON C revealed: *She had reviewed resident 3's and 69's care plans and there was no documentation that the residents' baseline care plans were reviewed with the resident or the resident's representative, that a copy was offered to them within 48 hours of admission to the facility. *She was not aware that documentation of the resident or resident's representative review of the baseline care plan or that they were offered a copy of it was required. 4. Review of resident 61's EMR revealed: *She was admitted to the facility on [DATE]. *Her 1/16/26 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated her cognition was moderately cognitively impaired. -There was no documentation that the baseline care plan was reviewed with the resident or the resident's representative, or that a copy was provided to them. -The staff member who completed the baseline care pan did not sign or date it. 5. Interview on 2/12/26 at 9:36 a.m. with ADON C revealed: (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The facility's process for completing residents baseline care plan begins before the resident's admission to the facility which included an interdisciplinary team (IDT) meeting being conducted to review and discuss the admission huddle checklist (checklist that described what the resident needed or liked while being at the nursing home). *Once the resident arrived and was settled in their room, the admission nurse would meet with the resident and their family to review the admission huddle checklist. *When the baseline care plan was completed it waw placed in a binder located at the nurse's station. *When the physician conducted their initial assessment of the resident, the resident's baseline care plan was presented by the facility to the physician for review. 6. Review of the provider's 5/5/25 Baseline Care Plan policy revealed: *The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. *A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. *A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. *A supervising nurse or MDS [Minimum Data Set] nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative. *The person providing the written summary of the baseline care plan shall: a. Obtain a signature from the resident/representative to verify that the summary was provided. b. A copy of the summary will be maintained in the medical record. *If the summary was provided via telephone, the nurse shall indicate the discussion, sign the summary document, and make a copy of the written summary before mailing the summary to the resident/representative.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed nursing professional standards of practice for following physician's orders for insulin administration for one of one sampled resident's (67) who was administered according to the physician's order by one of one observed licensed practical nurse (LPN) (H). Findings include:1. Observation and interview on 2/11/26 at 8:20 a.m. with LPN H in resident 67's room revealed she was checking the resident's blood sugar level. The amount of Novolog (insulin) she would administer to the resident was contingent upon the resident's blood sugar level.Resident 67's blood sugar level was 232. LPN H was not surprised that the number was a little high because the resident had already eaten two breakfasts that morning.2. Interview and review of resident 67's medication administration record (MAR) on 2/11/26 with LPN H revealed there was a 5/24/25 Novolog insulin physician order that indicated, based on the resident's blood sugar level of 232, that she was to receive three units of Novolog. The order also indicated that Novolog was to be administered before meals.LPN H acknowledged she did not follow the physician's order to administer resident 67's Novolog before the resident had eaten breakfast. LPN H knew that Novolog was a rapid-acting insulin (starts working within five to ten minutes of administration) and was used to improve blood sugar control, which was why it was ordered to be administered before meals. She stated it was difficult to ensure that morning blood sugar testing and insulin administrations for residents occurred at their scheduled times due to the number of residents who required morning blood sugar testing and insulin administration.3. Interview on 2/11/26 at 5:00 p.m. with assistant director of nursing (ADON) C revealed she expected LPH H to administer resident 67's Novolog according to the physician's order, but that did not occur.Review of the provider's revised 5/7/25 Medication Administration policy revealed 10. Ensure that the six rights of medication administration are followed. Those rights included administering medication at the e. Right time.