STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435035	A. BUILDING _____ B. WING _____	**10/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to ensure infection control practices were followed for the current coronavirus 2019 (COVID-19) pandemic for correct use of alcohol based hand sanitizer in 15 of 19 randomly observed residents' rooms (101, 103, 104, 106, 107, 201, 203, 211, 216, 218, 306, 315, 316, 402, and 411) on four of four residential halls. Findings include: 1. Observations on [DATE] between 11:00 a.m. and 12:30 p.m. of the following residents' rooms revealed: *There was a hand sanitizer dispenser mounted on the wall directly inside each resident's room. *The hand sanitizer dispensers in rooms 101, 103, 104, 106, and 107 had expired [DATE]. *The dispensers in rooms 201, 203, 211, 216, and 218 had expired [DATE]. *The dispensers in rooms [ROOM NUMBER] had expired [DATE]. *The dispenser in room [ROOM NUMBER] had expired [DATE], and the dispenser in room [ROOM NUMBER] had expired [DATE]. Interview on [DATE] at 1:35 p.m. with director of nursing (DON) B and administrator A regarding the above hand sanitizer dispensers revealed: *They were aware the dispensers had expired. *The manufacturers' of the sanitizer had stated they were only providing product for customers who had placed frequent orders with them. -The facility had not met that criteria and was not receiving sanitizer product from them. *The facility had requested hand sanitizer from the South Dakota Department of Health (SD DOH) in [DATE]. -Hand sanitizer was unavailable for distribution at that time, and the facility had not contacted the SD DOH again. *They believed the Centers for Disease Control (CDC) had issued a waiver that stated the use of expired hand sanitizer was acceptable. -They were unable to provide a copy of that communication. *Staff used the expired hand sanitizer prior to and following resident care. Review of the provider's undated Preparedness Plan revealed: *F. Personal Protective Equipment (PPE)/Disinfectants: -1. Facility will provide alcohol-based hand sanitizer for hand hygiene to be available in every resident room.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE