South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	67721	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT SKYLINE PINES	1050 FAIRMONT BLVD RAPID CITY, SD 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 5/6/25. Areas surveyed included nursing services and resident neglect. The Village at Skyline Pines was found not in compliance with the following requirement: S415.	S 000		
S 415	44:70:05:03 Resident Care The facility shall employ or contract with a licensed nurse who assesses and documents that the resident's individual personal care, and medical, physical, mental and emotional needs, including pain management, have been identified and addressed. Any outside services utilized by a resident shall comply with and complement facility care policies. Each resident shall receive daily care by facility personnel as needed to keep skin, nails, hair, mouth, clothing, and body clean and healthy. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and job description review, the provider failed to ensure the individual care needs for one of one sampled resident (1) had been assessed and documented by one of one registered nurse (RN) (B) related to his change in condition. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted to the facility on 12/11/24. *His 3/16/25 Brief Interview of Mental Status (BIMS) assessment score was 10. That indicated he had moderate cognitive impairment. *The resident received his medical care from a	S 415	The Village had previously amended the RN job description to more specifically explain the expectations for assessments of a resident with a noted significant change in condition. Nurses will be re-educated by Administrator ,on threshold for identifying and charting any significant change in condition, including updating the Resident's individual care plan, and any outside service changes by other providers. Designee will pull 3 samples, if available, per week, of doc completed by a Nurse. These may include: Resident transfers to and from hospital / ER, Resident's with significant changes in med condition, falls, and/or instances when staff contact on-call nurse regarding Resident incidents. Doc samples will be reviewed by Administrator or designee, for proper engagement,charting, and applicable follow up. QAPI team will review the results of the audits each meeting and document the results. If no errors are found in 3 months, auditing will change to one interaction per week for 3 additional months.	6/20/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli J. Back | TITLE: Administrator | (X6) DATE: 6/4/2025

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S 415	Continued From page 1 Veterans Administration (VA) medical provider. *His diagnoses included essential hypertension (high blood pressure), atherosclerotic heart disease (thickened blood vessels in the heart), abdominal aortic aneurysm (swelling of a large blood vessel in the abdomen), benign prostatic hyperplasia (enlarged prostate gland that can cause difficulty with urination), and glaucoma. -On 3/20/25, the resident was hospitalized for treatment of a cerebral infarct (ischemic stroke) from a tear in the wall of his carotid artery (occurs spontaneously or due to trauma), which led to a blood clot forming. *There was no documentation prior to that hospitalization that supported the resident had a recent trauma. Interview on 5/6/25 at 11:45 a.m. with RN B revealed: *On 3/19/25, she was the overnight on-call nurse. At 8:46 p.m. she had received an e-mail from resident 1's son. -The resident had called his son at about 6:42 p.m. that evening and reported he was not able to see out of his left eye. He had not reported this to facility staff, so the son had asked someone to check on the resident. *RN B had called certified nurse aide (CNA)/unlicensed medication aide (UMA)/shift lead C and asked her to check on resident 1. -That had meant looking at the resident's eyes to see if there was a difference in the size of his pupils, seeing if his pupils had reacted to light, or if his eyes were able to track a moving object. -RN B was not able to remember if she had asked CNA/UMA/shift lead C to take the resident's vital signs. *CNA/UMA/shift lead C called the resident's daughter and reported to her what the resident had told her about his vision. The daughter	S 415		

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S 415	Continued From page 2	S 415		

planned to contact her brother about setting up an eye appointment for resident 1.
*RN B had not documented:
-She had called CNA/UMA/shift lead C after she had received the above e-mail.
-How she had instructed CNA/UMA/shift lead C to have checked on the resident.
-If or what CNA/UMA/shift lead C had reported back to her regarding her observations of resident 1 after she had checked on him.
-What, if any, follow-up instructions she had given to CNA/UMA/shift lead C after the resident was checked on.

Continued interview with RN B revealed:
*At 11:47 p.m. on 3/19/25 resident 1 had called her cell phone number and reported he was able to see again.
-She told the resident she would check on him the following morning.
*RN B updated CNA/UMA/shift lead C regarding that phone call and asked her to re-check the resident to determine what he was now seeing or not seeing.
*She had not notified the resident's medical provider of his vision changes because that provider was not able to be reached weekdays after 4:00 p.m.
*She had not updated administrator A regarding the resident's status.
*RN B had not documented:
-She had called CNA/UMA/shift lead C back.
-How she had instructed CNA/UMA/shift lead C to have re-checked the resident.
-If or what CNA/UMA/shift lead C had reported back to her regarding her observations of resident 1 after she had re-checked on him.
-Any follow-up instructions she had given to CNA/UMA/shift lead C after the resident was re-checked.

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S 415	Continued From page 3 -Why neither the resident's medical provider or administrator A had been updated on the resident's status. Continued interview with RN B regarding her 3/20/25 progress note completed at 8:17 p.m. revealed: *"After arriving this writer [RN B] and other RN D went to his [resident 1's] apartment to assess him." *There was no documentation to support: -At what time RN B and RN D had assessed resident 1. -If RN B had contacted the resident's VA medical provider regarding the resident's vision changes. *"[RN B and second RN] Left the [resident's] apartment and went to ED [administrator A's] office to give[a] report and received [a] call from [the VA nurse]..." "and was informed that resident [1] needs to go to the ER [emergency room] right now for evaluation." -The resident left the facility at 11:42 a.m. on 3/20/25 via the facility's van. After an evaluation in the hospital ER, resident 1 was admitted to the hospital. Continued interview with RN B regarding resident 1's 3/21/25 post-hospitalization return to the facility revealed: *She had not known what the status of resident 1's vision was. -No nurse assessment was completed for the resident after he returned from the hospital to the facility on 3/21/25. Review of resident 1's 3/16/25 revised care plan revealed: *There was no mention of his 3/20/25 new cerebral infarct diagnosis. *The only intervention related to his vision was	S 415		

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S 415	Continued From page 4 "he had bifocal glasses, but he does not always wear them." Interview on 5/6/25 at 2:45 p.m. with administrator A regarding resident 1's 3/19/25 acute vision changes and his 3/21/25 post-hospitalization nurse documentation revealed: *She confirmed RN B's 3/20/25 late entry progress note documentation for resident 1 was incomplete and lacked detail. *It had not reflected: -The communications RN B had with CNA/UMA/shift lead C during the evening of 3/19/25 or the actions, responses, and follow-up that had occurred as a result of their communication. -If RN B had notified resident 1's VA medical provider of his vision changes. -At what time RN B had assessed resident 1 on 3/20/25. *RN B should have updated administrator A on resident 1's vision status on the evening of 3/19/25 knowing the resident's VA medical provider was not able to be reached. A team decision, that included input from the resident's family, could have been made regarding resident 1's need for emergent medical care at that time. *It was the RN's responsibility to have completed a nurse assessment upon resident 1's post-hospital return to the facility and to have updated his care plan to reflect his current health status and changes in his care needs after he had returned from the hospital. Review of the provider's undated Registered Nurse job description revealed: *Job Summary: -"Report to the Administrator all emergencies;...""and observable changes in all	S 415		

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S 415	Continued From page 5 residents' behavior or health status that would indicate a change in their care plan." *Performance Requirements: -2. "Under the overall direction of the Administrator, develop and maintain systems that will effectively monitor the operation of the Resident Care program including, but not limited to Quality Care Plan and other quality care concerns." -5. "Supervises and ensures accurate and complete documentation of Admission and all subsequent Assessments of all current and prospective residents of the Community..." -6. "Exercises appropriate professional judgment in assessing and accurately completing, and immediately communicating to the Administrator, the resident, and/or his responsible party or significant other, any changes in the resident's physical or mental condition. RN will make effective recommendations for action to the Administrator and timely document all such changes. RN must assess any Residents, or delegate to another medically trained professional, that appear to have a change in condition."	S 415		