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 02/06/2025

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

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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 2/5/25 through 2/6/25. Areas surveyed included resident neglect and nursing services. The Village at Skyline Pines was found not in compliance with the following requirements: S337 and S701.	S 000		
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, review of a 2/6/25 email communication from the provider, policy review, and job description review, the provider failed to ensure professional standards of practice had been followed by one of one registered nurse (RN) (B) who failed to assess one of one closed sampled resident (1) and thoroughly document that resident's change in medical condition. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *His admission date was 6/11/21. He was moved to the memory care unit (MCU) on 4/24/24. *He participated in the Veteran's Administration (VA) home-based primary care (HBPC) program that had included routine VA nurse visits. His primary medical provider was based out of the nearby VA medical center.	S 337	As of the writing of this reply, Nurse B is no longer employed by the facility, due in part to the circumstances that contributed to this survey finding. The Village has ammended the RN job description to more specifically explain the expectations for engaging in the assessment of a resident with a noted significant change in condition and requirements to notify other staff if such assessment is not possible. Nurses will be directly instructed by Administrator on the expectation and any changes to the procedure. Nurses will be instructed by Administrator on threshold for charting and how this standard has been missed recently. We will have 3 interactions per week between care staff and Nurses reviewed by Administrator or designee for proper engagement and charting. If no errors are found in 3 months we will change to auditing one interaction per week for 3 further months. Changes will be in place not later than 3/3/2025	03/03/25

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

Kelli J. Back | Administrator | 3/5/2025

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*His diagnoses included dementia, respiratory failure with hypoxia (low oxygen levels), chronic obstructive pulmonary disease (COPD) (lung diseases that make it difficult to breathe), hypertension, anemia, anxiety, and benign prostatic hyperplasia (condition causing difficulty with urination).
*His 6/7/24 Brief Interview for Mental Status (BIMS) assessment score was 6 which indicated he had severe cognitive impairment.
*His January 2025 medication administration record (MAR) had included:
-A physician-ordered "COPD home action plan" that had included the use of Prednisone (steroid) and Azithromycin (antibiotic) if the resident had increased shortness of breath, cough, or mucus.
-Physician orders for two scheduled inhalers (for COPD) and two liters of oxygen administered "at rest, with activity, and during sleep".
*Resident 1 was hospitalized from 11/16/24 through 11/18/24 for treatment of acute on chronic respiratory failure with hypoxia and an adenovirus (a common repiratory virus) infection.

Continued review of resident 1's interdisciplinary progress notes (PN) revealed:
*A 1/13/25 PN written by resident care assistant (RCA) D: " Resident was acting unlike self wouldn.t [wouldn't] eat or drink without cueing all day. He is really shaky when holding his own drinks."
*A 1/20/25 late-entry PN by RN B regarding a change in resident 1's condition that occurred on 1/14/25: "Spoke with [HBPC VA nurse] - she gave ok for Prednisone [steroid] and Z-Pack [antibiotic] to start now. She had [resident 1's VA medical care provider] call me-- resident to go to hospital by non-emergent ambulance."
*There was no documentation regarding what had preceded RN B calling the VA nurse, no

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mention of any orders or instructions given to RN B by the VA medical care provider, and no indication if resident 1's family had been notified of his change in condition.
-There had been no documented notes RN B was notified of the above 1/13/25 observation documented by RCA D.
-There had been no documented assessments of resident 1 that were completed by RN B on 1/14/25.

Interview on 2/5/25 at 1:00 p.m. with RN B regarding resident 1's 1/14/25 change in condition revealed:
*She had not seen resident 1 or completed a nursing assessment of him after she was notified of his change in medical condition on 1/14/25.
*"Everything happened quickly [on 1/14/25]" and there was no time for her to have assessed him.
*RN B stated the method the facility used for resident documentation was "documentation by exception." That had meant resident documentation focused on deviations from what was normal or expected for the resident.
*She agreed resident 1's medical event on 1/14/25 would not have been normal or expected of him and therefore should have been documented.
-Documentation should have included a detailed accounting of what had occurred between the time she was notified of the resident's change in condition and the time he left the facility with emergency medical services (EMS) providers including her assessment(s) of the resident during the medical event, the resident's vital signs (what they had been, who had taken them, and the times they had been taken), any instructions she had provided caregivers related to the resident's condition, and who she had notified regarding the resident's change in condition.

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S 337	Continued From page 3 Interview on 2/5/25 at 4:15 p.m. with administrator A regarding resident 1's 1/14/25 change in condition revealed: *"When a nurse is on the property [inside of the facility], it is an expectation to have them do an in-person assessment [of the resident]' when a change in a resident's medical condition has been reported. -RN B should have notified her if she was not able to have assessed resident 1. Administrator A was a licensed practical nurse and could have evaluated the resident. *RN B's documentation of resident 1's medical event was not thorough and had not been completed in a timely manner. Review of the 2/6/25 e-mail received from administrator A regarding the 1/14/25 timeline of events involving resident 1 revealed: *At 11:19 a.m. resident care assistant (RCA)/unlicensed medication aide (UMA)/shift lead C had reported to RN B: -Resident 1 was struggling after his oxygen had been removed when he was assisted to use the toilet. "He was shaky. Toileting took 4 minutes and when brought back [to the dining room] his O2 [oxygen] was at 77 [77 % oxygen saturation level] and his hands were warm, temperature was normal, but BP [blood pressure] was 178/103." Resident 1 was "responsive and was breathing hard." *In between 11:19 a.m. and 12:59 p.m. RN B had: -Left a telephone message for the VA nurse regarding resident 1's condition (11:22 a.m.). -Called the MCU to request additional vital signs for the resident (11:24 a.m. and 12:14 p.m.). -Spoke with the VA nurse (12:23 p.m.) and the VA medical provider, and answered a call from the resident's family (12:50 p.m.).	S 337		

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S 337	Continued From page 4 *At 12:59 p.m. emergency medical services (EMS) was called. *One hour and 50 minutes had elapsed between the time RN B was notified of resident 1's change in medical condition and the time EMS had arrived (1:10 p.m.) to transport the resident to the local emergency department. -During that time resident 1 was not assessed by RN B. Review of the 3/15/21 Resident Care policy revealed: "The facility shall employ or contract with a licensed nurse who assesses and documents that the resident's individualized personal care, and medical, physical, mental and emotion needs have been identified and addressed." Review of the provider's undated Registered Nurse job description revealed: "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 changes in the residents physical or mental condition, and makes effective recommendations for action to the Administrator. Accurately, completely and timely documents all such changes." *"20. Use best medical judgment to ensure Resident/staff safety and health."	S 337		
S 701	44:70:08:01(1-6) Record Service The resident care records shall include the following: (1) Admission and discharge data including disposition of unused medications;	S 701	All Care and Nursing staff will be instructed at our March all staff meeting by a Nurse as to the importance of properly and timely charting changes to residents condition and communications with outside entities regarding care for the residents. All staff not at this meeting will recieve a handout outlining the information above and will be required to acknowledge they have read and understand the information. Nurse will audit 3 random occurrences per week for 3 months to verify compliance. If no errors are found we	03/20/25

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S 701	Continued From page 5 (2) Report of the physician's, physician assistant's, or nurse practitioner's admission physical evaluation for resident; (3) Physician, physician assistant, or nurse practitioner orders; (4) Medication entries; (5) Observations by personnel, resident physician, physician assistant, nurse practitioner, or other persons authorized to care for the resident; and (6) Documentation that assures the individual needs of residents are identified and addressed. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, policy review, and job description review, the provider failed to ensure complete and thorough documentation of one of one closed record sampled resident's (1) change in medical condition. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *His diagnoses included dementia, respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), hypertension, anemia, anxiety, and benign prostatic hyperplasia. *He participated in the Veteran's Administration (VA) home-based primary care (HBPC) program that had included routine VA nurse visits. His primary medical provider was based out of the nearby VA medical center *He required 2 liters of oxygen continuously. -His last oxygen saturation level was documented	S 701	will then monitor 1 occurrence per week for a further 3 months to verify compliance. All staff will be trained and compliance verification program will be in place not later than 3/15/2025.	

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on 1/14/25 at 9:44 a.m. and was 91%.
-His last set of full vital signs (blood pressure, pulse rate, temperature, and breathing rate) were documented on 12/31/24 after he had a fall.
*A 1/13/25 progress note (PN) documented by resident care assistant (RCA) D: " Resident was acting unlike self wouldn.t [wouldn't] eat or drink without cueing all day. He is really shaky when holding his own drinks."
-There was no indication this observation had been reported by RCA D to an unlicensed medication aide (UMA) or a licensed nurse for follow-up.

Interview on 2/5/25 at 12:30 p.m. with RCA D regarding her 1/13/25 PN above revealed she had reported her resident observation to RCA/UMA/shift lead C but had not documented that information in her PN.

Interviews on 2/5/25 at 12:15 p.m. and 3:30 p.m. with RCA/UMA/shift lead C regarding resident 1 revealed:
*She confirmed RCA D had told her on 1/13/25 that resident 1 was not feeding himself even after staff had prompted him to do so. That was "out of character" for the resident.
*Late morning on 1/14/25 resident 1 was assisted by staff to use the bathroom. His oxygen was removed while he used the bathroom.
-He was assisted back to a dining room table after he used the bathroom to "read" a newspaper. His oxygen had been put back on.
*RCA/UMA/shift lead C observed the resident had "slumped forward on the [dining room] chair". He had responded to her voice, but he was "groggy". She had taken his vital signs and reported those to RN B.
-She was instructed by RN B to reposition the resident in a recliner and she waited for further

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instruction from RN B who had called the resident's VA nurse.
*RN B called RCA/UMA/shift lead C back and instructed her to:
-Obtain another set of vital signs for resident 1. Those had been taken by RCA/UMA E.
-Administer steroid and antibiotic medications to the resident per the physician-ordered home COPD action plan.
*RCA/UMA/shift lead C thought she had documented in the resident's PNs her observations above of resident 1, his vital signs information that had been taken that day, and the instructions she had received from RN B after RN B had spoken with the VA nurse but she had not done that.

Interview on 2/5/25 at 12:45 p.m. with RCA/UMA E regarding resident 1 revealed:
*He had taken one of the sets of vital signs that had been requested by RN B on the morning of 1/14/25.
-He thought he had written them down on a piece of paper and taken them directly to RN B's office.
*He had not documented that vital sign information in resident 1's EMR but he should have.
*RCA/UMA/shift lead C had been "harping on us to do that [document pertinent resident information in their EMR]."

Continued review of resident 1's EMR revealed:
*A late PN entry, created on 1/20/25 at 1:56 p.m., by RN B immediately followed RCA D's 1/13/25 PN above: "Spoke with [HBPC VA nurse] - she gave ok for Prednisone [steroid] and Z-Pack [antibiotic] to start now. She had [resident 1's medical care provider] call me-- resident to go to hospital by non-emergent ambulance."
-There was no documentation regarding what had

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preceded RN B calling the VA nurse, no mention of any orders or instructions given to RN B by the VA medical care provider, and no indication if resident 1's family had been notified of his change in condition.
-There had been no documented assessments of resident 1 that were completed by RN B on 1/14/25.

Interview on 2/5/25 at 1:00 p.m. with RN B regarding resident 1's 1/14/25 change in condition documentation revealed:
*She confirmed there had been no documented vital signs on 1/14/25 for resident 1.
-It was the responsibility of the caregivers who had taken those vital signs to have documented them and not her.
*RN B stated the method the facility used for resident documentation was "documentation by exception." That had meant resident documentation focused on deviations from what was normal or expected for the resident.
-She agreed resident 1's change in condition on 1/14/25 would not have been normal or expected of him and she should have documented those events more thoroughly.
*She confirmed she had not documented a nurse assessment of the resident on 1/14/25.
-"Everything happened quickly" and she had no time to assess the resident even though she confirmed several hours had passed between the time she learned of his change in condition until the time he was transported out of the facility via ambulance.
-She agreed that would have been enough time to have personally assessed the resident.

Interview on 2/5/25 with administrator A regarding resident 1 revealed:
*She confirmed RN B, RCA/UMA/shift lead C,

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S 701	Continued From page 9 RCA D, and RCA/UMA E had missed opportunities to document information that had described pertinent details that preceded the resident's change in condition, staffs' actions, and how staff had responded to that change in condition that occurred on 1/14/25. Review of the 3/15/21 Resident Care policy revealed: "The facility shall employ or contract with a licensed nurse who assesses and documents that the resident's individualized personal care, and medical, physical, mental and emotion needs have been identified and addressed." Review of the undated Registered Nurse job description revealed: "5. Supervises and ensures accurate and complete documentation of Admission and all subsequent Assessment of all current and prospective residents of the Community..."	S 701		