STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43L001	A. BUILDING _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK HILLS CHILDREN'S HOME	24100 S ROCKERVILLE RD RAPID CITY, SD 57702

(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) COMPLETION DATE
N 000	Initial Comments A complaint survey for compliance with 42 CFR, Part 483, Subpart G, Subsection 483.354-483.376, Condition of Participation for the use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21, was conducted on 10/4/23. Black Hills Children's Home was found not in compliance with the following requirement: N214.	N 000	1. Education and training changes to achieve sustained compliance. *Bedtime Routine/Supervision policy added on 10/4/2023 by Program Director A. Overnight staff will physically enter the room and visually account for each child in their beds every 15 minutes and one random check every hour throughout the night and document those checks on the overnight log.	
N 214	EDUCATION AND TRAINING CFR(s): 483.376(a) The facility must require staff to have ongoing education, training, and demonstrated knowledge of - This STANDARD is not met as evidenced by: Based on record review, interview, review of the South Dakota Department of Health (SD-DOH) intake referral form, and policy review, the provider failed to ensure staff were aware of supervision and monitoring responsibilities for residents in a high-risk population to mitigate an alleged incident of resident-to-resident abuse between two of two sampled residents (1 and 2). Findings include: 1. Review of the facility-reported intake referral form submitted to the SD-DOH on 10/3/23 revealed: *Residents 1 and 2 had reported that on more than one occasion during the overnight shift on 9/26/23 and 9/27/23 resident 2 had been in resident 1's bed. -Physical contact between those residents had allegedly occurred during those times.	N 214	*The Best Practices Training Guideline form for the overnight training staff had training points added to it by the Program Director A on 10/4/2023. Under preparation to sit in a chair (The chairs must be positioned so you can view all beds. If you can't see a bed, reposition the chair). Under supervision (15-minute bed check policy #10). Under supervision (Electronics must be put away and nightly tasks be stopped while children are awake. TC B, who supervises the overnight RYC team that works the front half of the week provided the education and training for these changes to the overnight team that works the front half of the week on 10/7/2023 and had staff sign off on the policy. TC G, who supervises the overnight RYC team that works the back half of the week provided the education and training for these changes to the overnight team that works the back half of the week on 10/5/2023 and had staff sign off on the policy. Program Director A and Unit Coordinator's provided the education and training to all daytime RYC positions on the overnight expectations just in case they need to stay late on 10/13/2023 and had staff sign off on the policy. *The Orientation Training Schedule added: under supervision bullet point a reminder to train all RYC's on the overnight 15-minute bed check and chair placement policy.	10/16/2023

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

CEO | 10/31/23

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.

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N 214	Continued From page 1 Review of Resident Youth Counselor (RYC) F's 9/26/23 and 9/27/23 every 15-minute interval documentation in the "Blue Log" (Night Staff Child Sleep Log) revealed: *At 10:45 p.m. resident 2 had used the bathroom. *Between 11:00 p.m. and 11:40 p.m. resident 1 had been awake and singing. *At 11:45 p.m. resident 2 had been "fidgeting, making noise." *From 12:00 a.m. through 1:30 a.m. resident 1 was awake. *At 1:30 a.m. resident 1 and resident 2 had each gone to the bathroom. Resident 1 again used the bathroom at 3:30 a.m. *Between 3:30 a.m. and 4:30 a.m. resident 1 was awake. *Resident 2 was awake between 4:00 a.m. and 4:15 a.m. Interview on 10/4/23 at 9:15 a.m. with night shift team coordinator (TC) B revealed: *RYC F had worked the overnight shift on the East hall on 9/26/23 and 9/27/23 when the alleged incident referred to above had occurred. -She was responsible for the supervision and monitoring of the two rooms directly across the hall from one another on the end of the East hall. -Residents 1 and 2 had shared one of those two rooms with resident 3. *The primary responsibilities of the overnight shift RYC were to: -Position and sit in chairs outside of the resident's bedrooms that they were responsible for. -Completely see the inside of those rooms at all times while sitting in those chairs. -Ensure the bedroom night light was turned to its brightest setting to help visualize the inside of those rooms. -Step inside of those rooms no less than every 15	N 214	The overnight TC B and TC G will be responsible for educating the new overnight RYC's during their first 40 hours of orientation training about these training points and sign off on the orientation sheet they understand the expectations. An exam will be given after the completion of 40 hours orientation to demonstrate knowledge of the policies and procedures. This will be completed before they can be on the floor supervising children. The Program Director A will review the orientation sheets after they are completed to ensure new staff and their trainer are signing off on the training provided indefinitely. Unit Coordinator's will follow up with new overnight RYC's within 30 days of hire to ensure trainers are covering all training topics and to ensure staff have clear knowledge of and are following the expectations for supervision. Unit Coordinator's will follow up on staff training records quarterly to ensure the completion of quarterly trainings. The overnight TC B and TC G will also be responsible for completing the 3 and 6 month reviews for new overnight RYC's to assess compliance in these areas. *The Night Staff Child Sleep Log added by Program Director A: at the top of the page to physically enter room and visually account for each child and a box was added to document the intervention for an awake child on 10/11/2023.	

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N 214	Continued From page 2 minutes to confirm each resident the staff were responsible for was in their own bed. --TC B had used a flashlight to help him perform that duty. -Document those observations with every 15 minutes physical checks on the Blue Log. He had worked the overnight shift on 9/26/23 and 9/27/23 had: *Observed RYC F and RYC C's chairs to have been facing each other in the East hall. -"Assumed they did what I do" with regard to placing their chairs in a manner that allowed them to have completely visualized the inside of the bedrooms that they were responsible for monitoring. -"They all know that" was the expectation of the chair positioning. *TC B stated resident 1 had been awake during most of the overnight shift referred to above. -She had been singing but not in a manner that had been disruptive to other residents. *He had entered her room at about 3:30 a.m. that night to attempt to determine the reason she was unable to sleep. -Her inability to sleep that night was "unusual" because she usually slept through the night. *TC B was responsible for the training and supervision of the overnight shift RYCs. -New staff had received some on-line training, reviewed facility policy and procedures, and had "shadowed" other staff during their orientation. *He was responsible for ensuring their understanding of the expectations of their job responsibilities. Interview on 10/4/23 at 9:45 a.m. with RYC C regarding the night of the alleged incident revealed:	N 214	-TC B was notified by Program Director A of the incident on 9/29/2023. -TC B who supervises the overnight RYC staff on the front half of the week reviewed the incident with his overnight RYC team to provide adequate supervision on 10/1/2023. RYC C and RYC F are on TC B's team. -TC B and TC G were emailed on 10/2/2023 by Program Director A about the findings of the incident and immediate training needed in the areas of the use of the night log and 15-minute expectations, what the expectation is when there is an awake child, and chair placement to supervise bedrooms. -TC B and TC G were given updated overnight training guidelines by Program Director A on 10/4/2023 to review with all the overnight RYC's and have each staff sign off on the addition to the bedtime routine/supervision policy and place that in their individual training record. -TC B and TC G were given an updated night staff child sleep log by Program Director A on 10/15/2023 to print off and replace the old form to capture the changes made to the log.	

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N 214	Continued From page 3 *She was responsible for the supervision and monitoring of the residents in the other two rooms on the East hall not supervised and monitored by RYC F. *Resident 1 had not been sleeping that night but she was not disruptive with the other residents. -Residents 1 and 2 had been up and used the bathroom at different times during that night. *RYC F, TC B, and RYC C had entered resident 1 and 2's room at different times during that night to try to determine why resident 1 was unable to sleep. *She had heard a "loud thump" at about 4:00 a.m. -Resident 2 stated she had "dropped something" which had caused the noise. *RYC C had suggested to RYC F that she go into that room to check on things but she was unable to recall if RYC F had followed that suggestion. -She had also suggested to RYC F that she "keep her eyes on them," indicating both residents 1 and 2. *RYC C had been employed in her current position for about two years. *Her understanding of the overnight staff supervision and monitoring of residents: -Was the ability to visualize all the residents that she was responsible for in their rooms from the chair she had sat in and monitored from. *TCs had not trained her to have entered a resident's room every 15 minutes to verify their presence in their beds. Telephone interview on 10/4/23 at 2:00 p.m. with RYC F revealed: *Her hire date was in May 2023 and her training had been provided by TC F and TC G. *Her understanding of the overnight staffs supervision and monitoring of the residents were: -To have visually checked on each resident she	N 214	2. Action Plan for staff member involved. RYC C, TC B, Program Director A, and HR met on 10/11/2023 and discussed the verbal warning documentation of the incident. TC B provided training to RYC C on 10/7/2023 and made the expectations clear. The verbal warning includes following all above training and procedures for supervising or it could lead up to termination of RYC C's employment. TC B will follow up on supervision expectations on 10/29/23 and 11/26/23 to ensure follow through and document that on the training log. Program Director A will review the training log on those specific dates to make sure the monitoring is occurring. Action Plan for staff member involved. RYC F, TC B, Program Director A, and HR met on 10/11/2023 and discussed the Performance Improvement Plan created for the lapse in supervision. TC B provided training to RYC F on 10/7/2023 and made the expectations clear. The performance improvement plan includes following all above training and procedures for supervision or it will lead to termination of RYC F's employment. TC B will check on RYC F nightly for compliance and document that on the night log. TC B will follow up with RYC F monthly during 1 on 1 meetings for a full quarter to review the performance improvement plan and progress made.	

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N 214	Continued From page 4	N 214		

was responsible for every 15 minutes from the chair she had sat in.
-To have completed a physical count of the residents she was responsible for at the start of the shift.
--There had been no expectation for any other regular physical checks of the residents during the night unless it was indicated.
*If an unusual noise was heard coming from a resident she would have made eye contact with that resident and spoke to them from the hallway.
*She had sat in a chair at the end of the hallway on the night of the alleged incident with the back of that chair faced towards the bathroom behind it.
-She leaned forward in that chair or used her feet to pull the chair forward to fully visualize the inside the rooms she was responsible for monitoring and supervising that night.
*Resident 1 was awake most of the night and that had been unusual.
*RYC F had heard "increased activity" in resident 1 and 2's room after midnight.
-Between then and about 3:30 a.m. RYC C had entered the room once, TC B once, and she had entered the room twice.
-She was not sure if resident 2 was in her own bed during those times she had entered the room but had seen no one but resident 1 in resident 1's bed.
*Between 3:30 a.m. and 3:45 a.m. RYC F again heard increased noise coming from that same room and between 4:00 a.m. and 4:15 a.m. a "rumbling" noise resembling the sound of someone turning in bed.
*RYC F's understanding of cell phone use during work was that they were not to have been used before 11:00 p.m. or after 6:00 a.m. -No cell phone use was expected when a resident was

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N 214	Continued From page 5 awake. -She had used her cell phone at different times throughout the night of the alleged incident when the residents she was responsible for monitoring and supervising were awake. Interview on 10/4/23 between 8:50 a.m. and 9:10 a.m. with program director A regarding the allegation of resident-to-resident abuse between residents 1 and 2 revealed: *Both residents had confirmed that during the overnight hours on 9/26/23 and 9/27/23 resident 2 had been in resident 1's bed more than once. -Physical contact between them had occurred that night. *His investigation of the alleged incident included an interview with RYC F that revealed she had: -Not positioned her chair in such a manner that resident 1 and 2's room were able to have been completely visualized by her. -Not entered their room to confirm residents 1 and 2 had been in their own beds no less than every 15 minutes. -Used her personal cell phone during those times when she had known residents 1 and 2 were awake in their bedroom. *RYC F had lacked complete awareness of her supervision and monitoring responsibilities that might have mitigated the alleged incident of resident-to-resident abuse between residents 1 and 2 from occurring. Review of RYC F's new employee training revealed: *RYC F's Orientation Training Schedule had included six hours of new employee orientation, four hours of program orientation and six hours of safe crisis management training. -She also had completed Fundamental	N 214		

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N 214	Continued From page 6 Competencies at Orientation (specific job functions) which included supervision of the residents. -An additional 40 hours of ongoing training was scheduled to have occurred throughout her first year of employment. *Her training had been completed under the direction of TCs B and G. Interview on 10/4/23 at 11:50 a.m. and review of the unrevised Best Practices Training Guidelines (Overnights) with program director A revealed: *That four-page document included job-related expectations specific to the overnight staff. -It had consisted of "talking points" for the TC to refer to when they had oriented overnight RYC staff. -Those "talking points" were expected to have been discussed by the TC with newly hired RYCs during their first 30 days of employment. *The Guidelines had: *Only referenced the need for physical checks of the residents to have occurred: "Before sitting down, do a physical bed check so that each child [resident] is accounted for and in the correct place." *Not referenced the need for chair positioning to have been in a direct line of sight of all the beds in the bedrooms staff were responsible for supervising. Interview on that same date at 2:30 p.m. with program director A and review of the facility's unrevised Bedtime Routine/Supervision policy revealed no mention of the following: *The expected frequency of or the physical or visual expectations for the accountability of the residents required during the overnight shift. *The documentation expectations of the	N 214		

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N 214	Continued From page 7 accountability referred to above. *It had been program director A's responsibility to ensure TCs B and TC G had provided their staff completed RYC training in a manner to have enabled the RYCs to perform their jobs as expected.	N 214		

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{N 000}	Initial Comments A revisit survey was conducted on 11/9/23 for deficiencies cited on 10/4/23. All deficiencies have been corrected, and no new noncompliance was found. Black Hill Children's Home is in compliance with all regulations surveyed.	{N 000}		

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