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 08/14/2024

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 8/14/24. The area surveyed was staff to resident abuse. The Village at Skyline Pines was found not in compliance with the following requirement: S838.	S 000		
S 838	44:70:09:09(4) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: 4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, personnel file review, interview, policy review, review of the 8/12/24 Department of Human Service's (DHS) Report of Suspected Dependent Adult/Elder Abuse, and review of a video received from a complainant supporting the 8/12/24 DHS Report, the provider failed to ensure one of one closed record sampled resident (1) was free from verbal abuse and potential physical harm by one of one resident care assistant (RCA) (D) and one of one certified nurse aide (CNA)/unlicensed medication aide (UMA) (E). Findings include: 1. Review of resident 1's electronic medical	S 838	On 8-14-24 our facility was made aware during this survey of the allegation of verbal abuse towards a resident and possible improper or unsafe transfer of a resident. Upon investigation it appeared that both allegations were valid and substantiated. Findings were as follows: RCA D made demeaning statements to Resident 1 about her family member, and also about the amount of time taken to get ready for bed. RCA D also used improper transfer techniques to transfer resident from chair to wheelchair which could have caused injury to resident 1, herself, or others. CNA/UMA E made demeaning comments to Resident 1 about her family member, and about the amount of time taken to get ready for bed. CNA/UMA E failed to follow policy when assisting in a transfer of Resident 1 to wheelchair and that failure could result in the injury of the resident, herself, or others. During interview with DOH present, both employees stated that they were trained on resident rights, and knew that statements made were inappropriate. Both employees stated that they were trained on transfers and knew the policy, but chose to ignore it. Plan of correction: RCA D was terminated from employment by Administrator A. CNA/UMA E was terminated from employment by Administrator A. Police were called and informed of the abuse allegations for both employees. All staff have/will be educated at all staff meeting scheduled for 9/11/24 by General Manager that negative verbal comments towards a resident can be deemed abuse and such comments have no place in our facility. All care staff have/will be reminded by Administrator at all staff meeting scheduled for 9/11/24, that the transfer policies/ procedures are in place for the safety of the residents and staff and MUST be followed at all times.	9-11-2024

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

Kelli J. Back | Administrator | 8/30/24

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S 838	Continued From page 1 record (EMR) revealed: *She was admitted to the facility on 11/9/23 and she was 94 years old. *Her diagnoses included: dementia (late onset) without behavioral disturbance, cerebral infarct, hemiplegia (paralysis) affecting the right side, diabetes, anxiety, depression, insomnia, and bilateral osteoarthritis of the knee. *Her 1/9/24 Brief Interview for Mental Status score was "10" which indicated she was moderately cognitively impaired. Review of RCA D's personnel file revealed: *Her date of hire was 1/3/24. *She received gait belt (a safety device used to help someone move) education on 1/31/24 and Vulnerable Adult (resident abuse and neglect) education on 2/26/24. Review of CNA/UMA E's personnel file revealed: *Her date of hire was 11/17/23. *She received gait belt education on 11/17/23 and Vulnerable Adult education on 1/1/24. *Her CNA and UMA certifications were current. Review on 8/14/24 at 1:30 p.m. of the video referred to above from the complainant with administrator A, general manager B, and assistant administrator C revealed: *RCA D and CNA/UMA E entered resident 1's room on 7/28/24 at about 8:21 p.m. and RCA D transferred resident 1 from her recliner to her wheelchair. *During that transfer: -RCA D did not verbally prepare or talk resident 1 through the transfer process in an appropriate manner. --RCA D stated only: "Let's get in bed" and "Let's go" as she moved the resident from her recliner to her wheelchair.	S 838	In order to identify any potential abuse, cognitively intact Residents will be asked how they are treated by staff during day to day tasks. The Administrative team will be tasked with asking one conitively intact Resident and one Family member of a not cognitively intact Resident how they are being treated per week for 6 weeks, then quarterly there after for 9 months. Results will be recorded and Families will be reminded at that time if they feel there is lack of dignity or respect that they are to notify Administrator A immediately. As a result of a potentially non-safe transfer, the administration team will be responsible for conducting the following audits to ensure compliance: 2 times per week for the next 6 weeks, then quarterly thereafter All staff will be also be educated during the same team meeting on 9/11/24 that observation and audits will be conducted to ensure compliance.	

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S 838	Continued From page 2 -She transferred the resident without a gait belt. That action increased the risk of the resident falling or incurring physical harm. --RCA D placed her forearms under the resident's armpits and lifted her from her recliner seat. When she pivoted the resident to her wheelchair, one side of the resident's face was pressed against RCA D's upper body which caused the resident's glasses to move off the bridge of her nose. -RCA D disregarded the resident when she said: --"Oh, oh, oh, don't do that" as when RCA D physically lifted her off the seat of her recliner. --"Oh, oh" as the resident held her right side during the transfer. --"My knee" as RCA D lowered the resident to her wheelchair seat. -RCA D cursed ("Damn radio") in the vicinity of the resident. *CNA/UMA E: -Did not lock the resident's wheelchair brakes before the resident was transferred. That put her at unnecessary risk for physical harm if the wheelchair had moved and may have caused the resident to fall. -Did not intervene when resident 1 was inappropriately transferred by RCA D. -Interacted with the resident in a demeaning manner when she used the following words while assisting her into bed: "C'mon (unintelligible words) go to bed," "No you're not ..." (unintelligible words), [You are] "damn ornery" and "Oh, whatever." Interview on 8/14/24 from 6:05 p.m. to 6:25 p.m. with RCA D regarding the contents of the video referred to above revealed: *On the evening of 7/28/24 she and CNA/CMA E responded to resident 1's family's request to check on the resident in her room.	S 838		

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S 838	Continued From page 3 -RCA D transferred resident 1 from her recliner to her wheelchair. *Regarding her verbal interaction with resident 1 before and during the transfer referred to above RCA D stated, "I came off harsh. I've been working on that." *Regarding the curse word she used, she said, "I have a bad mouth. I shouldn't have said that." -She agreed her language used and how she had spoken to resident 1 was verbally aggressive. *Regarding how she transferred resident 1 as observed in the video revealed: -Two staff were expected to have transferred resident 1 in case the resident's "legs gave out" during the transfer. --She had not asked CNA/UMA E to help her because "she [CNA/UMA E] won't help." --She could have asked for help from another staff person but failed to do so. -A gait belt was expected to be used when resident 1 was transferred but the resident "doesn't like a gait belt". --Failing to use the gait belt and transferring the resident by lifting her under her armpits increased the resident's risk for a fall or physical injury. *Regarding her failure to acknowledge resident 1's complaints of discomfort during the transfer, RCA D said she: -Reassured the resident by whispering in her ear when resident 1's head was pressed against her during the transfer. -Felt she had supported the resident's knee with her body during the transfer so she knew a knee injury was unlikely. Interview on 8/14/24 between 6:35 p.m. and 7:05 p.m. with CNA/UMA E regarding the contents of the video referred to above revealed: *She remembered "going up there [to resident 1 ' s room] to check on her [the resident]" the	S 838		

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S 838	Continued From page 4 evening of 7/28/24. -She did not know if another staff was with her at that time. *In response to the demeaning and verbally aggressive interactions made by either she or RCA D towards resident 1 that were heard in the video she stated: "I don't remember saying those things." "We're usually pretty mellow." -She knew staff "shouldn't talk to them [residents] that way". *Regarding the failure to have locked the wheelchair brakes prior to resident 1's transfer CNA/UMA E stated: "I wouldn't lock the wheelchair brakes because the resident usually just slid herself from the [recliner] seat to her wheelchair [seat]." *When it was described to her how resident 1 was transferred per the video CNA/UMA E: -Agreed resident 1's wheelchair brakes should have been locked. "She [resident 1] could have fallen." -She stated a gait belt was expected to have been used during all resident transfers. *She would not have reminded RCA D to use a gait belt and said: "I don't know. I'm not good at telling people what to do." *CNA/UMA E had no recollection of resident 1 verbalizing any discomfort during the transfer. -She stated the resident complained about her knees "all the time." "Her knees are always hurting." She described resident 1 as a "drama queen" and "everything is a big deal" whether she was hurting or not. "It's her [referring to resident 1]" and she "didn't take her [resident 1] seriously." *In response to verbal comments heard on the video referred to above and made in resident 1' s bedroom when only CNA/UMA E and the resident were in the resident's room, CNA/UMA E stated, "I could have [said those things], probably did." -She agreed those comments were verbally	S 838		

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S 838	Continued From page 5 aggressive and demeaning. Review of the provider's revised 5/1/22 Transfer Assistance policy revealed: "3. Utilize a gait belt whenever possible when assisting a resident without the use of a lift." Review of page 5 of the provider's undated ALC Tenant Handbook revealed: *Abuse Prevention Plan: -"All new employees will be screened by the state for criminal and civil prosecution of abuse or neglect. -Residents are given the Bill of Rights handbook. -Complaints will be investigated within 24 hours."	S 838		