STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435097	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Andes Senior Living	740 East Lake St Lake Andes, SD 57356

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50915 Based on review of the provider's South Dakota Department of Health (SD DOH) facility reported incident (FRI), interviews, observation, and record review, the provider failed to keep one of one resident (1) safe from elopement. Findings include: 1. Review of the provider's SD DOH FRI revealed: *On 10/1/24 at 7:02 p.m., Resident 1 walked to the front door of the facility, pushed on the door, and exited the facility without supervision. *He was wearing a Wanderguard (a wearable device that alarms when individual is within proximity of an alarmed door and/or crosses the threshold of alarmed door). -The Wanderguard functioned appropriately and alarmed when the resident exited the building. *At the time the resident exited the building, all staff were assisting other residents. *CNA G spotted resident 1 across the street at a neighboring house. *CNA G brought the resident back to the facility at 7:07 p.m. *Resident 1 was assessed by licensed practical nurse (LPN) D, the resident was not injured, and his vital signs were within normal limits. *Resident 1's daughter was notified, as well as his primary care provider. *The facility initiated 15-minute checks for the following 72 hours. 2. Interview on 10/15/24 at 3:05 p.m. with CNA E and CNA F revealed: *They stated that resident 1 would try to exit the building frequently. *They stated he had gotten physically aggressive with staff at times when they tried to redirect him. (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*They stated that to verify the resident's Wanderguard was working correctly, they would walk the resident near the exit, and would hear the alarm if it was working. -They said if the resident got outside, there was a different alarm to alert staff the resident had exited the building. 3. Interview and observation on 10/15/24 at 3:30 p.m. with administrator A revealed: *Resident 1 was known for his exit seeking behaviors. *He demonstrated to the surveyor how the front door was locked until the numerical code was entered to exit. *He stated that door would alarm when a resident wearing a Wanderguard was near it. *He demonstrated that by pressing on the door for 15 seconds which unlocked the door, as a fire safety feature. 4. Interview on 10/16/24 at 8:36 with regional nurse consultant B revealed: *Her definition of an elopement is A resident getting out of the building without staff knowing. *She stated that resident 1's incident Was not really an elopement because the alarm went off and he was retrieved immediately. *She stated that elopement drills were conducted quarterly by the facility but was unable to provide documentation of the drills. 5. Interview on 10/16/24 at 8:40 a.m. with director of nursing (DON) C revealed: *She confirmed that resident 1 exited the front door unaccompanied on 10/1/24. *She stated the resident headed west and was found in a neighboring yard on the other side of the road by CNA G. 6. Interview on 10/16/24 at 11:00 a.m. with LPN D revealed: *She recalled on the evening of the incident, she was doing med pass on the east wing when resident 1 exited the building. *She stated that resident 1 had exited the building one time before and was found on the ground outside. *She stated that on the night of that incident, she was in another resident's room and was unable to hear the alarm while inside the room. *When asked if there was adequate staffing on night shifts, she replied it would be nice to have a second 6-10 p.m. CNA. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*When asked if resident 1's elopement may have been prevented if there was additional staff, she replied Yes. *When asked if the facility performed missing person drills, she replied that she remembered doing one a long time ago. *She confirmed the resident did leave the premises and was found in a neighboring yard on the other side of the street. -She confirmed that the missing person drills were not conducted regularly on the night shift. 7. Review of resident 1's electronic medical record (EMR) revealed: *His care plan identified him as being at risk for elopement. *His progress notes revealed he attempted to exit the facility frequently. -Several progress notes related to his exit seeking and wandering were documented on 8/8/24, 8/16/24, 8/31/24, 9/23/24, 9/24/24, 10/1/24. *Orders in the resident's medical record directed staff to check the Wanderguard function twice daily. -All checks were documented that the Wanderguard was functioning correctly. -On 9/23/24 and 9/24/24, progress notes indicated resident 1 was able to exit through the front door and the Wanderguard did not alarm.