STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St Milbank, SD 57252

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, observation, document review, record review, and policy review, the facility failed to ensure the safety for one of one sampled resident (48) who was identified at risk for elopement (leaving the facility without staff knowledge) and left the building unsupervised on 9/19/25. Findings include:1. Review of the 9/19/25 FRI report submitted to the SD DOH revealed: *On 9/18/25 at 8:47 p.m., resident 48 exited out of the facility's back door. *Another resident's family member heard the alarm and called a staff member who was not on duty and notified her that the alarm was sounding. That staff member called the facility and told the nurse on duty, and she went out and assisted resident 48 back inside. *The wander guard alarm sounded at the door, at the alarm panel, and an alert was sent to the radio staff wore. *Staff did not hear the alarm going off at the panel because no staff was in that area at that time. Not all staff heard the alert on their radio. -Two certified nursing assistants (CNA) heard the alert on their radio but they were assisting other residents and were not able to immediately respond. -One CNA was on break and had the radio turned down and was unable to hear it. -One CNA had her radio in her pants pocket and the volume had accidentally been turned down. -One nurse did not have a radio, and the other nurse on duty left her radio on the medication cart and was not near it. 2. Interview on 2/18/26 at 12:45 p.m. with maintenance director U revealed: *He checked that the wander guard door alarm functioned appropriately monthly by bringing a wander guard near it to see if it alarmed. *If the wander guard alarm sounded, a code needed to be entered on the wander guard panel to turn the alarm off. (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 - Minimal harm or potential for actual harm Residents Affected - Few	*There was a keypad next to the front door. If a code was not entered prior to leaving the front door, the door would alarm. The alarm would turn off when the door closed, without staff needing to enter a code. 3. Observation and interview on 2/19/26 at 8:54 a.m. with ward secretary V revealed: *An alarm on the panel by the CNA station alarmed, she reviewed the cameras, did not see anyone or an open door, so turned the alarm off. *She did not need to go check the door. 4. Observation on 2/19/26 at 9:45 a.m. of resident 48 in her room revealed she was sitting in her recliner reading a book, and both of her walkers had a wander guard on them. 5. Observation and interview on 2/19/26 at 9:49 a.m. with CNA DD revealed: *She was a travel CNA, and it had been six months since she had worked at the facility. *She did not receive any education after coming back to the facility. *The alarm on the panel by the CNA station sounded. She stated, I don't know what this is for, walked over to the panel, pushed a button that silenced the alarm, and did not look into why the alarm was sounding. 6. Interview on 2/19/26 at 10:15 a.m. with CNA collaborator W revealed: *She worked at the facility for about a year. *When the door panel by the CNA station alarmed, they were to look at the camera to see if they saw anything suspicious on it, and then turn the alarm off if they didn't. *If they did not see anything on camera then they did not need to go check the door. *If she heard the wander guard alert over the radio, or the alarm on the wander guard panel sound, she would go and check that door. *The wander guard alert did not alarm at the CNA station, and it sounded at the door and needed a code to turn it off. *She recalled talking about elopements at a CNA meeting, she completed a video training, but she did not recall receiving training since September 2025. *She sometimes carried a radio, if one was available. *There was a sign that hung at the CNA station that reminded staff how to alert others of a missing resident by overhead page. They were to look for the resident in resident rooms, and to check the sign-out book. 7. Interview on 2/19/26 at10:26 a.m. with CNA H revealed: (continued on next page)

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

*She had worked at the facility for about five months.

*If the door panel alarmed, she was to review the cameras to see if someone was there or if the door was open.

*She was supposed to go check the door to see if anyone had gotten out.

*An alert went to the staff's radios that said wander guard and the location.

*All staff were to carry a radio.

*The CNA sheets (a document that identifies residents' care needs and interventions) identified residents who wore wander guards.

*There was a list of residents who wore wander guards that were in a binder in the report room.

*She recalled having education regarding elopements for her new hire education, and they had monthly CNA meetings.

8. Interview on 2/19/26 at 11:52 a.m. with licensed practical nurse (LPN) G revealed:

*She had worked at the facility for a year and a half.

*Wander guards were to be checked every shift to ensure they were functioning by bringing the resident who wore the wander guard by the exit to see if the alarm went off.

*She was not sure who was responsible for testing the wander guards, and it was not documented on the medication or treatment record.

*The wander guard alarm sounded at the panel by the exit door, and it sounded at the control panel by the CNA station.

*She took the radio out of her pocket, looked at it, and stated that it was on the incorrect channel, channel 4, and it needed to be on channel 1.

*The wander guard did not send an alert to radios, but they used the radios to ask staff to locate residents.

*After resident 48 eloped, she recalled receiving education regarding elopements and having the doors to the unit closed in the evenings.

*There was a list of residents who wore wander guards in a binder in the report room.

9. Interview and document review on 2/19/26 at 12:09 p.m. and 1:54 p.m. with director of nursing (DON) B revealed:

*Resident 48 had an elopement assessment completed last on 10/25/24 that indicated she was at risk for elopement, had eloped once before, and was to wear a safety exit alarm (wander guard), and was to be checked on frequently.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	carry their radios, and to have the volume turned up. *She was unsure who was all educated, but stated the dietary staff were because they were the ones to close the doors to the unit in the evenings. *They completed audits that the doors were being closed, brought those to QAPI, and determined they did not need to be continued. 10. Interview and document review on 2/19/26 at 1:45 p.m. with administrator A revealed: *She did in-service regarding the elopement policy on 9/22/25. *Every department provided the education to their areas, and staff who were at the meeting read the elopement policy. *Staff who did not attend that meeting were to read the elopement policy and sign that they had read it. *Review of the education sign-off sheets revealed thirty-four staff, including nine managers, signed that they received the elopement education. She verified that not all the staff received that education, and they should have. 11. Review of resident 48's electronic medical record (EMR) revealed: *Her 12/11/25 Brief Interview for Mental Status (BIMS) assessment score was 9, which indicated she had moderate cognitive impairment. *She had an order entered on 11/9/25 for her wander guard sensor to be checked on both of her walkers three times a day, in the morning, at night, and at bedtime. *Her 12/9/25 care plan indicated she: -Was admitted on [DATE]. -Had Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and bodily functions) -Had a BIMS score that indicated moderate cognitive impairment. -Wandered and got lost looking for her room. -Had a wander guard on her merry walker (type of walker). -Was unaware of her own safety, and the staff were to monitor her wander guard and respond if she set that alarm off. 12. Review of the CNA sheets revealed that resident 48 had a wander guard. 13. Review of resident 48's September 2025 through February 2026 treatment record revealed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*September 2025 and October 2025 did not indicate that the wander guard was checked. *On 11/9/25 the wander guard was added to check it three times a day. *11/9/25 through 2/17/26 was signed off as checked once a day at bedtime. 14. Review the provider's 9/19/25 Elopement/Missing Resident policy revealed: *Each resident at [facility] will be provided a safe environment in which to reside. *Wandering is a behavior that is characteristically associated with dementia, therefore residents with this diagnosis are observed upon admission. *[Facility] does not have a secure or locked unit, therefore the facility has installed a WanderGuard system which consists of sensors (worn by identified residents displaying wandering behaviors) and sensor detector strips that are at or near exit doors. *These residents are routinely monitor4ed [monitored] to assure they do not purposefully cut the strap and/or that the sensor is activating when it is supposed to do so. Another safeguard [facility] has implemented is installing auxiliary audible local alarms on interior doors of the facility. These alarms are activated when the interior door is opened which enables staff to reach the resident prior to exiting the building. These alarms sound until staff physically reset them. *The doors from the resident hallway (Farmer's Fairway) to the dining room will be closed following the evening meal and/or around evening snack. The door at the end of Farmer's Fairway will also be closed as added security.