

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43844</p> <p>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, observation, interview, record review, and policy review, the provider failed to ensure the safety of one of one sampled resident (21) who eloped (left the facility without staff knowledge) when a visitor exited the building. This citation is considered past-noncompliance based on review of the corrective actions the provider implemented following the incident. Findings include:</p> <p>1. Review of the provider's submitted SD DOH FRI regarding resident 21 revealed:</p> <p>*On 10/29/24 at 2:10 p.m., resident 21 followed an unidentified visitor out the front door of the facility.</p> <p>*The visitor had used a key fob to unlock the door and once in the parking lot the visitor realized resident 21 was a resident.</p> <p>*The visitor assisted the resident back into the lobby of the facility where staff were present.</p> <p>-Upon his return, the resident was assessed with no injuries and was dressed appropriately for the weather that day.</p> <p>-At the time of the elopement, resident 21 was in the main lobby of the facility attending a birthday party.</p> <p>*The facility was considered a locked unit, all exterior doors of the building were locked, and the front door had a delay of ten seconds before closure after it was opened.</p> <p>Review of resident 21's medical record revealed:</p> <p>*He had a diagnosis of dementia</p> <p>*His Brief Interview of Mental Status score was 4, which indicated he had severe cognitive impairment.</p> <p>*He resided in the memory care unit.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*His care plan included he was ambulatory and had a history of wandering.</p> <p>-Interventions for his wandering included:</p> <p>-Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book.</p> <p>-Monitor the resident's location every fifteen minutes.</p> <p>-Offer diversion activities when resident begins talking about leaving facility.</p> <p>-Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes.</p> <p>The provider implemented systemic actions to ensure the deficient practice does not reoccur by having:</p> <p>*Notified families in the monthly newsletter and posted signage at the facility's exits that there are residents who wander and not to let residents out of the facility without staff knowledge.</p> <p>*Provided education to staff members regarding the elopement policy.</p> <p>*A practice elopement drill was conducted.</p> <p>*Ensured their FRI's were presented at the next Quality Assurance meeting.</p> <p>*An exit door in the memory care unit had been frosted, which maintains the natural light but obscures the view of the exit.</p> <p>*There have been no other elopements.</p> <p>*Visitors have been monitored to ensure they are following instructions and ensuring residents do not follow them out.</p> <p>The provider's implemented systemic actions to ensure the deficient practice does not reoccur was confirmed on 12/19/24 after record review revealed the facility had followed their quality assurance process, education was provided to all staff about the resident's elopement, and observations and interviews revealed staff understood the education provided regarding those topics.</p> <p>Based on the above information, non-compliance at F689 occurred on 10/29/24, and based on the provider's implemented corrective actions for the deficient practice confirmed on 12/19/24, the non-compliance is considered past-noncompliance.</p> <p>51816</p>		