

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Sanford Chamberlain Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S Byron Blvd Chamberlain, SD 57325	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844</p> <p>Based on record review, observation, interview, and policy review, the provider failed to ensure the South Dakota Department of Health (SD DOH) had been notified of two of three incidents of elopement for one of one sampled resident (24).</p> <p>Findings include:</p> <p>1. Review of resident 24's medical record revealed:</p> <p>*He was admitted on [DATE].</p> <p>*His diagnoses included dementia with behavioral disturbances and Alzheimer's disease.</p> <p>*His Brief Interview of Mental Status (BIMS) score was a 99, which indicated the interview was not successfully completed.</p> <p>*He had eloped from the facility on 3/1/24, 3/24/24, and 7/10/24.</p> <p>*On 3/1/24 a nurse's progress note indicated:</p> <p>-resident was found outside the [NAME] end door.</p> <p>-Two certified nursing assistants (CNAs) were putting residents to bed and stated they did not see resident leave the building.</p> <p>-[Another resident] was yelling out that the resident [24] had gone out of the North end door on [NAME] household and the door alarm was going off.</p> <p>-Resident was brought into the [NAME] end [NAME] door and walked to the [NAME] household. Wander guard [Wander Guard] [a bracelet door alarm device] remains in place on residents left wrist and is working.</p> <p>*On 3/24/24 a nurse's progress note indicated:</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Front door alarm of the Care Center was alarming. This nurse went to investigate and found that resident went through the double doors and was walking but not yet made it to the parking lot. He was easily re-directed back into facility. Resident has a birthday today and seems a little anxious.</p> <p>Interview and record review on 7/11/24 at 2:35 p.m. with director of nursing (DON) B and director of nursing trainer (DON) M regarding resident 24 revealed:</p> <p>*DONT M indicated he had eloped once, in the last year.</p> <p>-He had pushed open the door and walked out.</p> <p>*On 3/1/24 a resident had alerted staff that he had exited the building.</p> <p>-DONT M had not considered this an elopement as it was witnessed by another resident.</p> <p>*On 3/24/24 he had walked out the front double doors onto the sidewalk.</p> <p>-DONT M had not considered this an elopement as he had not made it into the parking lot.</p> <p>-DON B indicated he had no knowledge of resident 24's elopements on 3/1/24 and 3/24/24.</p> <p>*On 7/10/24 resident 24 had eloped again.</p> <p>*After review of resident 24's nurse's progress notes from 3/1/24 and 3/24/24, DONT M confirmed those incidents had been elopements and should have been reported to the SD DOH.</p> <p>Review of the provider's 7/10/24 Security Alert: Missing Person-Elopement policy revealed:</p> <p>*Upon return of the resident to the facility, the following steps will be carried out:</p> <p>-An incident report will be completed.</p> <p>-The person responsible for the resident's care shall initiate an appropriate plan of treatment.</p> <p>-The resident's care plan will be revised to reflect elopement and prevention plan developed.</p> <p>-Elopement assessment will be completed.</p> <p>-Care planning team will meet each week and as needed to investigate any elopements to ensure safety of all residents and to prevent any elopement from reoccurring.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45095</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (24) identified at risk for developing skin injuries and who had acquired a skin injury (wound) received:</p> <p>*Timely skin assessments performed by professional licensed staff.</p> <p>*Timely notification to his physician to obtain orders for treatment.</p> <p>Findings include:</p> <p>1. Observation and interview on 7/11/24 at 4:20 p.m. with nursing supervisor and wound care nurse (NS/WCN) H regarding resident 24's wound revealed:</p> <p>*He was in his room sitting in his recliner watching television.</p> <p>*When asked to observe his wound he gave his permission and was able to reposition, stand, ambulate and reposition his pants independently.</p> <p>*He had an approximate 1.3 centimeter (cm) length by 0.2 cm width by .02 cm deep open wound with a skin flap near the center left inner buttocks.</p> <p>*The wound was clean, and had no drainage.</p> <p>*NS/WCN H stated the wound had been deeper but was healing from the inside out.</p> <p>*He was prone to and had a history of boils to that same area.</p> <p>*The wound was being treated with Mepilex (an absorbent foam dressing).</p> <p>*NS/WCN H had been asked to look at the wound on 6/26/24 at the end of the day by the staff nurse who had worked that evening shift.</p> <p>*The wound had been assessed by physical therapy and determined the cause of the wound was not related to pressure.</p> <p>43844</p> <p>Review of resident 24's medical record revealed:</p> <p>*He was admitted on [DATE].</p> <p>*His diagnoses included dementia with behavioral disturbances and Alzheimer's disease.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*His Brief Interview of Mental Status (BIMS) score was a 99, which indicated the interview was not successfully completed.</p> <p>*His 7/11/24 care plan had a focus initiated on 7/28/22 that indicated he had impaired skin related to redness of abdominal folds and/or his groin and was receiving treatment.</p> <p>-The interventions for this focus included:</p> <p>--Conduct a systematic skin inspection every week with baths & [and] PRN [as needed].</p> <p>--Monitor and record any complaints of pain/itching/discomfort (location, durations, quantity, quality, alleviating factors, aggravating factors).</p> <p>--Administer medications/treatments as ordered, obtain lab/diagnostics as ordered, monitor for improvement.</p> <p>*His July 2024 treatment administration record revealed an order initiated on 6/27/24 that indicated he had an open wound to his left buttock.</p> <p>-On 7/2/24 a physician order for Mepilex and Medihoney [wound healing product] to left buttock every 3 days and PRN.</p> <p>Review of the C.N.A. [certified nursing assistant] SKIN INSPECTION REPORT form for resident 24 revealed a licensed nurse had dated and signed each form and the forms:</p> <p>*Identified on 6/17/24 a sore on his right buttock.</p> <p>*On 6/19/24 there were no skin impairments identified.</p> <p>*Identified on 6/21/24 redness to his groin area and swollen on both lower legs.</p> <p>*Identified on 6/24/24 a sore was identified on his left buttock.</p> <p>*On 6/26/24 there were no skin impairments identified.</p> <p>*Identified on 6/28/24 an open sore to his left buttock.</p> <p>Interview on 7/11/24 at 3:00 p.m. with director of nursing (DON) B regarding resident 24's buttock wound revealed:</p> <p>*On 6/26/24 at approximately 5:00 p.m. WCN/RN H had assessed resident 24's buttocks, found a wound on the left side of his buttock, and she had placed Mepilex on it.</p> <p>-She had not notified his primary care provider or his family at that time.</p> <p>*On 6/27/24 DON B and NS/WCN H had assessed resident 24's left buttock and they were unable to determine the type of wound it was.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45095</p> <p>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure the safety of one of one sampled resident (24) who eloped (left the facility without staff knowledge) and while he was outside of the building, fell and required evaluation at the emergency department.</p> <p>Findings include:</p> <p>1. Review of the SD DOH FRI revealed:</p> <p>*On 7/10/24 resident 24 had walked out the front double doors of the building without staff knowledge.</p> <p>2. Observation on 7/11/24 at 11:16 a.m. of resident 24 in his room revealed:</p> <p>*He had small scabbed-over lacerations to the top of his nose, and his upper and lower lip.</p> <p>*He was smiling, laughing, pleasant, cooperative, and conversive with intermittent garbled and nonsensical speech.</p> <p>3. Interview on 7/11/24 at 11:27 a.m. with registered nurse (RN) J revealed:</p> <p>*RN J had worked as a permanent staff member for five months and had not worked the previous evening when resident 24 eloped.</p> <p>*Resident 24 moved into the facility a year ago, was ambulatory, and did not use any assistive devices to ambulate.</p> <p>*Residents were assessed for risk of elopement on admission and when newly identified as at risk for elopement.</p> <p>*The social worker was notified when residents were identified as at risk for elopement and obtained orders for a Wander Guard (bracelet door alarm device).</p> <p>*Resident 24 wore a Wander Guard wristwatch, was never known to take his Wander Guard off, had gotten out of the facility the evening prior, and had a history of eloping in the past.</p> <p>*Staff monitored resident 24 closely, but there were no set times or frequencies for rounds (staff checks of resident status and care needs) or documentation of rounds.</p> <p>*Staff communicated at shift change report and he felt the certified nursing assistants (CNAs) were good at reporting to the nurse if residents were observed to have had increased wandering or risk of elopement behaviors.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*The Wander Guard was resident 24's primary intervention for his risk of elopement.</p> <p>4. Interview on 7/11/24 at 11:39 a.m. with CNA K revealed:</p> <p>*She had worked as a permanent staff member for one year and had not worked the previous evening when resident 24 eloped.</p> <p>*She had heard that resident 24 had gone out of the front door, tripped, fell , hit his nose, and was taken to the emergency department.</p> <p>*The resident had a Wander Guard watch, and no residents removed their Wander Guards that she was aware of.</p> <p>*They monitored residents closely, approximately every thirty minutes, when they went up and down the hallways but there were no set times or frequencies or documenting of that.</p> <p>*Staff communicated at shift change report, and in a communication book at the nurse's station. The CNAs reported to the nurse if residents were observed to have had increased wandering or risk of elopement behaviors.</p> <p>43844</p> <p>5. Review of resident 24's medical record revealed:</p> <p>*He was admitted on [DATE].</p> <p>*His diagnoses included dementia with behavioral disturbances and Alzheimer's disease.</p> <p>*His Brief Interview of Mental Status (BIMS) score was a 99, which indicated the interview was not successfully completed.</p> <p>*He had eloped from the facility on 7/10/24.</p> <p>*A 7/10/24 a nurse's progress note indicated:</p> <p>-Noted by activities coordinator that a passerby said someone was lying facedown on the concrete outside the building. CNA staff ran out there and found resident. As I was getting to the resident I could see blood coming from his mouth and nose. He appears to have cut his bottom lip and has a small laceration to the top of his nose. Resident was able to roll with assistance to his side and was sat up right. He was then assisted up and into a wheelchair. The bleeding is minimal. In examining the resident his nose appeared to be misshapen.</p> <p>-Decision made to send to ED [emergency department] for evaluation of this.</p> <p>-On 7/10/24 a follow-up nurse's progress note indicated:</p> <p>--Resident has returned from ED and ruled out fracture or acute head injury.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>--Of note, it was determined residents fall was witnessed, by the time the CNA's were getting to him to assist him back to the building, he fell then.</p> <p>6. Review of resident 24's 7/11/24 care plan revealed:</p> <p>*An initiated focus on 11/16/21, and revised on 4/11/24, that he experienced wandering due to his dementia, wandered without a destination or any safety awareness, and had a WanderGuard on his left wrist.</p> <p>-The goal for this focus was that he would wander safely within the specified boundaries.</p> <p>--There were no boundaries specified.</p> <p>-The interventions for this goal included:</p> <p>--Equip resident with a wander guard [WanderGuard] device that alarms when wanders, apply to left wrist. Check for proper functioning of device every night and skin breakdown.</p> <p>--Avoid over-stimulation (e.g., noise, crowding, other physically aggressive residents).</p> <p>--Maintain a calm environment and approach to [resident 24].</p> <p>--Remove [resident 24] from other resident's rooms and unsafe situations.</p> <p>7. Review of resident 24's July 2024 treatment administration record revealed:</p> <p>*A 1/4/24 order to monitor for Wander guard [WanderGuard] on at all times (left wrist) with daily activation check at night.</p> <p>*The diagnosis for this treatment was Unspecified dementia with behavioral disturbance.</p> <p>8. Review of resident 24's 7/10/24 Elopement Risk assessment revealed:</p> <p>*He had wandered in the past 60 days.</p> <p>*His diagnoses included dementia and Alzheimer's disease.</p> <p>*Contributing factors to this elopement were Repeatedly Opening Doors/Setting Off Alarms of Secured Doors and Wandering With No Rational Purposes And Attempting To Open Doors.</p> <p>9. Interview on 7/11/24 at 2:35 p.m. with director of nursing (DON) B and director of nursing trainer (DONT) M regarding resident 24 revealed:</p> <p>*On 3/1/24 a different resident had alerted staff that resident 24 had exited the building.</p> <p>*On 3/24/24 resident 24 had walked out of the front double doors onto the sidewalk.</p> <p>*On 7/10/24 resident 24 had walked out of the front double doors onto the sidewalk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-He had tripped and fallen while coming back into the building.</p> <p>10. Interview and review of a video recording on 7/11/24 at 3:40 p.m. with DON B and director of finance N revealed:</p> <p>*At 7:36 p.m. resident 24 held one side of the front double doors for 12 seconds until it opened and walked through the door and exited the building.</p> <p>*At 7:37 p.m. a staff member exited the bathroom in that area, looked through the front double doors, shut off the alarm, and walked around the corner to a different hallway.</p> <p>*At 7:38 p.m. two CNAs ran from the way the staff member above had gone to the front double doors and exited the building.</p> <p>*At 7:40 p.m. a nurse went to the front double doors and exited the building.</p> <p>*At 7:43 p.m. that same nurse returned inside while she talked on her cellphone.</p> <p>*At 7:44 p.m. that same nurse and another CNA exited the building through the front double doors.</p> <p>*At 7:46 p.m. that same nurse, and three CNAs returned with resident 24, seated in a wheelchair back inside the building.</p> <p>11. Interview on 7/11/24 at 4:10 p.m. with nursing supervisor/wound care nurse (NS/WCN) H, DON B and DONT M regarding resident 24's elopement revealed:</p> <p>*Interventions in place for his elopements included staff were to monitor him during normal rounding every two hours and a Wander Guard was placed on his wrist.</p> <p>-They indicated there were no other interventions in place to prevent him from elopement.</p> <p>12. Review of the provider's 7/10/24 Security Alert: Missing Person-Elopement policy revealed:</p> <p>*Upon return of the resident to the facility, the following steps will be carried out:</p> <p>-An incident report will be completed.</p> <p>-The person responsible for the resident's care shall initiate an appropriate plan of treatment.</p> <p>-The resident's care plan will be revised to reflect elopement and prevention plan developed.</p> <p>-Elopement assessment will be completed.</p> <p>-Care planning team will meet each week and as needed to investigate any elopements to ensure safety of all residents and to prevent any elopement from reoccurring.</p>		