

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  01/09/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32355</p> <p>Based on South Dakota Department of Health (SD DOH) 1/2/25 facility-reported incident (FRI), observation, interview, record review, and policy review, the provider failed to:</p> <p>*Ensure there was a plan of action implemented following an incident where one of one sampled resident (1) had become physically aggressive with staff and had struck another resident (2) in the face during the interaction.</p> <p>*Ensure one of one sampled resident (1) who had cognitive impairment was free from psychological and physical abuse by three of three certified nursing assistants (CNA) (G, K, and L) during an episode of the resident having had increased agitation and aggression.</p> <p>*Ensure extended education and training on how to take care of residents with dementia and psychosocial behaviors for all staff had occurred to help them assist one of one sampled resident (1) during episodes of increased agitation and aggression.</p> <p>*Ensure all direct care-givers had knowledge of how to access and review updated care plan changes for the residents.</p> <p>Findings include:</p> <p>1. IMMEDIATE JEOPARDY NOTICE</p> <p>Notice of immediate jeopardy was given verbally and in writing on 1/8/25 at 4:57 p.m. to licensed social worker (LSW) A, executive assistant D, and director of finance M for F600:</p> <p>*The provider failed to have an immediate plan of action in place and implemented following an incident that occurred on 1/2/25. *When resident 1 had become physically aggressive with staff and had struck resident 2 in the face during that occurrence.</p> <p>*His behaviors are impulsive, unpredictable, and have the potential to cause harm to both the residents and staff.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*Through interviews, document review, and video review, it was identified that there was no plan or education presented to the staff on how to address their ongoing concerns about how to assist the resident during those episodes to ensure the safety of the residents and staff had occurred.</p> <p>*A plan for the removal of the immediacy was requested at that time.</p> <p><b>IMMEDIATE JEOPARDY REMOVAL PLAN</b></p> <p>On 1/9/25 at 4:43 p.m. the provider gave the following acceptable immediate jeopardy removal plan:</p> <p>*On 1/8/2025 1309 [1:09 p.m.] a message was sent to residents' psychiatric provider with updates on behaviors. Verbal orders were received by a nurse 1-9-2025 from Psych Provider stated to discontinue Hydroxyzine [allergy and anxiety medication] and to use the PRN [as needed] Seroquel [antipsychotic]. He is also scheduled with the Psychiatric provider for a revisit on 1/13/25. PRN pain medication Tylenol has been scheduled instead of PRN, and Labs CBC, and CMP are ordered by PCP.</p> <p>*1/8/2025 starting at 0645 pm [6:45 p.m.] In person Dementia training Lewy Body Dementia What Everyone Needs to Know was given to staff from day shift and for the overnight. [Name] Administrative Assistant who is Teepa Snow Dementia certified. Training will resume in the morning at 0630-830 [6:30 a.m. - 8:00 a.m.], 12-2 [12:00 noon - 2:00 p.m.], and 3:30-5:30 [3:30 p.m. - 5:30 p.m.] and will continue until all staff are educated before their next scheduled shift. Monitoring of efficacy will be done by scenario role playing drills of all staff by picking random 5 people per week for 1 month and 5 random people a month for 6 months will be documented.</p> <p>*1/9/2025 education on how to find care plans was sent to all staff via email and put on each kiosk, and by the nurse's station computers. Will do one to one education with each staff and they will sign they have received the education. Care plan updates will be added to the 7-day sheet which is communicated in the report to nurses and CNA. MDS [Minimum Data Set] or designee will monitor care plan documentation to the seven-day sheet for updates only from the care plans that were updated weekly for 3 months.</p> <p>*1-8-2025 Residents whole care plan was reviewed to ensure appropriate for resident and if any updates needed to be established. Care plan was updated with ways to approach resident from the front instead of the side or from behind do [due] to diagnosis of dementia. Resident is care planned one to one. One to one is provided as definition of one to one is 1 person assigned to resident that focuses on 1 person needs, abilities, strengths, and interests during staff to resident one to one situation while awake.</p> <p>*Cameras will be monitored especially on nights and weekends random 1-hour snips will be viewed 5 times per week for 1 month 3 times a week for 6 months and will be reviewed at that time for further discussion.</p> <p>*To ensure the safety of all the residents who are likely to suffer or have suffered serious adverse outcomes we are doing current medication review for the resident. We have been in contact with his Psychiatric provider in person. Education for staff including training on dementia before working next shift and setting up quarterly training through the state's ombudsman program.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The immediate jeopardy was removed on 1/9/25 at 4:43 p.m. after the survey team verified the provider had implemented their removal plan through document review and staff interviews. After the removal of the immediate jeopardy, the scope and severity of the citation level was an H. Current census was 44.</p> <p>2. Review of the provider's 1/2/25 submitted SD DOH FRI regarding resident 1's interaction with resident 2 revealed:</p> <p>*His Brief Interview for Mental Status (BIMS) assessment score was zero which indicated he was severely cognitively impaired.</p> <p>*[Resident 1's name] was laying on the floor next to the window, CNA attempted to assist resident off the floor, [the resident] attempted to go after another CNA chasing her, swung his arms as he was running and hit another resident in the face [and] made contact with her right cheek.</p> <p>*Investigation Conclusion:</p> <p>-Investigation started. Separated the resident and staff tried to get [resident 1's name] out of dining room. LSW [licensed social worker] came in and assisted to get his [him] calmed down and then got him ready for bed. Staff stated [resident 1's name] got upset and threw up his arms and hit [resident 2's name].</p> <p>-Called and updated [resident 1's name] PCP [primary care provider] and will update his psych [psychiatry] provider tomorrow. Plans going forward will continue to monitor [resident 1's name] and will wait and see if his providers make any changes.</p> <p>-The facility has reached out to HSC [Human Service Center] and [behavioral health provider's name] through November and December and have been told his [he] [resident 1] doesn't need an inpatient stay.</p> <p>*No documentation that indicated how the staff should have monitored and assisted resident 1:</p> <p>-To ensure the safety of the other residents and staff during episodes of increased agitation.</p> <p>-Until they received further direction from his providers.</p> <p>-To help decrease his agitation and aggressive behaviors.</p> <p>-No documentation that indicated if resident 2 had been assessed for injury after being struck in the face by resident 1.</p> <p>3. Observation on 1/7/25 at 12:50 p.m. of resident 2 in the dining room revealed:</p> <p>*She had been sitting at the dining room table visiting with another resident.</p> <p>*She was pleasantly confused and answered simple questions.</p> <p>*They had just finished lunch and the dirty dishes remained on the table.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 1/7/25 at 1:50 p.m. and again on 1/8/25 at 11:00 a.m. with CNA E revealed:</p> <p>*She was a traveling CNA and had been working at the facility for approximately two months.</p> <p>*Her dementia and abuse training had been through the mandatory online courses.</p> <p>-She had completed those upon hire at the facility.</p> <p>-There had not been additional training on dementia care outside of those online courses.</p> <p>*She had worked with resident 1 frequently and he had required a lot of staff to take care of him when he was agitated.</p> <p>*She stated:</p> <p>-Nothing will trigger him and he will just start throwing stuff, like chairs, anything in front of him.</p> <p>-He pushes and hits at the staff.</p> <p>-He'll start fighting with you when you try to take care of him. Sometimes it takes three of us to work with him.</p> <p>-He's hit other residents too.</p> <p>-It's happens almost daily.</p> <p>-He only likes the office staff.</p> <p>-The office staff take him to their office sometimes when he is awake.</p> <p>-When they're not here we just have to deal with it.</p> <p>-Yeah, it's scary because I don't want to get hit.</p> <p>-I just get the nurse or someone who knows him when he acts like that.</p> <p>*He had required one to one (one staff assigned to one resident) monitoring when he was awake.</p> <p>*The CNAs were assigned to him and when he was awake someone had to stop helping on the floor and stay with him.</p> <p>-No additional staff were scheduled to work with him.</p> <p>*She stated:</p> <p>-When there are just two CNAs, one of us stops helping on the floor and work just with him.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He hit her on the cheek and it left a mark across it.</p> <p>*A dementia training had been offered a couple of months ago.</p> <p>-The training had been offered from 11:00 a.m. to 3:00 p.m. and was not mandatory.</p> <p>-Anyone working during that time, students, and the night shift staff would not have been able to participate in that training.</p> <p>-She was unsure if it had been recorded.</p> <p>*She was not aware of a plan on how to take care of residents like resident 1.</p> <p>*She was not aware of any mandatory or updated training and education after above incident between residents 1 and 2.</p> <p>Interview on 1/7/25 at 3:45 p.m. with CNA G revealed:</p> <p>*He had been a college student and only worked during holiday leave.</p> <p>*He was required to catch-up on additional trainings and education prior to working.</p> <p>*Regarding resident 1:</p> <p>-He had worked frequently with the resident and was aware of his episodes of increased agitation and aggression.</p> <p>-The resident was to have one to one monitoring by staff when awake.</p> <p>-He was sporadic in allowing assistance with personal cares and toileting.</p> <p>-At times it would take two or three CNAs to assist him.</p> <p>-He had a history of biting, kicking, screaming, spitting, and hitting at staff when they had tried to calm him down or assist him with cares.</p> <p>-He had increased behaviors almost daily. Those behaviors occurred mostly during the evening hours when the office staff had left for the day.</p> <p>-No one was aware of what triggered his behaviors. Those behaviors were sporadic and hard to control.</p> <p>-There had not been extra staff scheduled to take care of him when he was awake.</p> <p>-A CNA would have been pulled off the floor to work with him during those times.</p> <p>-That would have left them short staffed on the floor to assist other residents with transfers, cares, and to answer their call lights.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*She had been working on 1/2/25 when resident 1 had become upset, aggressive, and hard to calm down.</p> <p>-The incident happened just after dinner and during the nurse's shift report.</p> <p>-He had sat down on the floor and the staff assisted him up off of the floor.</p> <p>-He had bumped into another resident on his way out of the dining area.</p> <p>-He went into the kitchen area and was assisted into a Broda chair.</p> <p>-The police were called per the direction of the on-call staff.</p> <p>-Being in the Broda chair calmed him down and he was calmer by the time the police arrived.</p> <p>-He had not hit resident 2 but rather brushed up against her. She did not have a red mark on her face, it appeared to be an age spot.</p> <p>-Resident 2 had been uninjured and did not remember the incident shortly after it occurred.</p> <p>-There had been a video recording of the incident and she had watched it.</p> <p>-After resident 1 was assisted off the floor he had taken off with his arms flying and brushed up against resident 2.</p> <p>*She had provided verbal education to the staff at that time on resident 1's care plan interventions.</p> <p>-He should have been left to lay on the floor per his wishes.</p> <p>*She stated:</p> <p>-We talk about him all the time and we tell the staff what they should do.</p> <p>-He is a priority, we talk about him daily.</p> <p>-Those staff should tell the other staff.</p> <p>*There was no documentation that indicated she had provided that verbal education.</p> <p>*There was a clipboard at the nurse's station that contained updated resident care plan information.</p> <p>-Sometimes those updates were given verbally to the direct care staff.</p> <p>-She agreed if it had not been documented there was nothing to support that education had been provided.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Sanford Chamberlain Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S Byron Blvd Chamberlain, SD 57325	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-She would have expected those staff to inform the other staff of any care plan changes/updates.</p> <p>*She stated: Everyone knows to use it [regarding the clipboard at the nurse's station] they use it every day.</p> <p>*Resident 1 was on a one to one monitoring plan and staff were assigned to take care of him on the daily sheet at the nurse's station.</p> <p>-The staff had been pulled off the floor to work with the resident when he was awake.</p> <p>-The nurse and med aide had been expected to assist with transferring and answering other residents' call lights during that time.</p> <p>-During the daytime hours, resident 1 spent a lot of his time with the office staff to help assist with the one to one monitoring.</p> <p>-Those office staff had not been there on weekends or after daytime hours to have assisted with resident 1.</p> <p>*She was not aware of any additional training, education, or updates regarding resident 1's episode on 1/2/25.</p> <p>*She stated:</p> <p>-There is extra hands-on training for dementia care in the works.</p> <p>-In the meantime we are trying to keep him a one to one.</p> <p>-No, the one to one is not a new change for him.</p> <p>*She agreed the staff should have had hands-on dementia care training sooner.</p> <p>Interview on 1/8/25 at 9:56 a.m. with licensed practical nurse (LPN) F revealed:</p> <p>*She had been working the evening of 1/2/25 when resident 1 had an outburst.</p> <p>-He had been agitated prior to her leaving the area for the nurse's change of shift report.</p> <p>-She had walked with him until he had calmed down prior to that meeting.</p> <p>-A CNA came and got her out of the report room to help with resident 1.</p> <p>-Resident 1 had sat on the floor and the staff had attempted to assist him with standing.</p> <p>-He became upset and ran after CNA K and in the process had hit resident 2 in the face.</p> <p>-He was uncontrollable and was in the kitchen area going through the refrigerator.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The staff helped him to sit down in his Broda chair.</p> <p>-Most of the time the Broda chair was a comfort for him.</p> <p>-She called the on-call administrator and was instructed to call the police.</p> <p>-She checked resident 2's right cheek and it had a large reddened area and measured it. It was not raised or hurtful to the resident.</p> <p>*The CNA assigned as resident 1's one to one that evening was fearful of him and had been involved in other episodes of his agitated and uncontrolled aggressive behaviors.</p> <p>*Resident 1:</p> <p>-Had frequent, almost daily outbursts of uncontrollable and aggressive behaviors.</p> <p>-During those episodes he had been hard to calm down and would start hitting, scratching, biting, and kicking at staff.</p> <p>-There had been times when LPN F had walked with him during those episodes and he hit and scratched at her.</p> <p>-She had received bruises from his hitting.</p> <p>-She had not filled out an incident report on all of those resident-to-staff occurrences because she thought nothing would have changed with his plan.</p> <p>-His behaviors were unpredictable because they were sporadic, quick, and it was hard for staff to tell what would have triggered an onset of increased aggression.</p> <p>-Most of the staff had been scared of him because of his aggressive behaviors.</p> <p>-During the daytime hours through the week days he spent most of the time in LSW A's office. She thought the LSW had a good relationship with the resident.</p> <p>*He had been placed on one to one monitoring after the last complaint survey on 10/31/24.</p> <p>-The direct caregivers working the floor had all been assigned to do that task.</p> <p>-Whoever was available would take over the one to one task with him when he was awake.</p> <p>*No extra staff had been scheduled to provide his one to one monitoring only the already scheduled staff.</p> <p>-At times this would have left them short staffed on the floor to assist the other residents with transfers, cares, and answering resident call lights.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-She had not received extra training on what the one to one person should have done when working with him.</p> <p>-There had not been extra staff scheduled to assist or monitor him when he was awake.</p> <p>-Whoever was available would have provided the one to one monitoring.</p> <p>-That staff person still had other residents to take care of and tasks.</p> <p>-The needs of the other residents had to wait until a staff person was available to assist them.</p> <p>-She had been instructed that the one to one resident had taken priority over the other residents.</p> <p>-She thought resident 1 had been neglected because of his increased behaviors. There had been times he had sat in his bowel movement because they had been to scared to change him.</p> <p>*She stated. Sometimes it takes up to three of us to change him or work with him so that no one gets hurt or kicked.</p> <p>*She had:</p> <p>-Not felt that she had the proper training to help take care of resident 1 and other residents with similar behaviors.</p> <p>-Not been aware of any updates or changes to his plan of care since the incident on 1/2/25 to ensure the safety of others and himself.</p> <p>-Had not been kept informed of when the resident's care plans had updated or changed.</p> <p>*She stated. One time a resident's diet changed to puree [food blended to a smooth consistency] and the only reason I knew that was because it was on the sheet they checked to see what the resident's wanted.</p> <p>*She had not completed any dementia care training and to her knowledge the online course was not mandatory.</p> <p>*She stated:</p> <p>-I've been told there is an upcoming training.</p> <p>-But they also said it won't be for a while now because all the students were going back to school</p> <p>Interview on 1/8/25 at 1:43 p.m. with director of nursing (DON) B revealed:</p> <p>*The online dementia training that should have been completed by 11/29/24 per their plan of correction from the 10/31/24 survey was for their ancillary staff only.</p> <p>-Such as, dietary, maintenance, and housekeeping.</p> <p>(continued on next page)</p>

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