STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A139	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flandreau Santee Sioux Tribe Care Center	909 Jones Dr Flandreau, SD 57028

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to ensure the safety of one of one sampled resident (14) identified at risk for elopement, who had eloped (left the facility without staff knowledge). Failure of staff to ensure adequate supervision put him at risk for physical injury or serious harm. This citation is considered past non-compliance based on the corrective actions the provider implemented immediately following the incident. Findings include:1. Review of the SD DOH FRI regarding resident 14 revealed:*On 7/9/25 at approximately 5:10 p.m., resident 14 had been seen on the unit by one nurse and two certified nursing assistants (CNAs). *At approximately 5:12 p.m., the front door wander guard alert system alarm sounded.*At 5:19 p.m., CNA F responded to the alarm at the front door, checked the front of the building and the front parking lot. Having not seen anyone, she returned to the facility, shut off the alarm, notified staff, and a facility search was initiated.*At 5:22 p.m., RN G began to search the surrounding area in her vehicle and located resident 14 at 5:36 p.m. walking down [NAME] Drive.-That was approximately two tenths of a mile from the facility.-He stated he was going to visit his sister, then accepted a ride back to the facility.*Director of nursing (DON) B was notified at 5:28 p.m. and notified administrator A at 5:32 p.m.*Tribal police were notified and responded to the facility as resident 14 returned to the facility. 2. Review of resident 14's electronic medical record (EMR) revealed:*He was admitted on [DATE].*His diagnoses included vascular dementia (a group of symptoms affecting memory, thinking, and social abilities), diffuse traumatic brain injury (a brain injury caused by an outside force), epilepsy (a neurological condition characterized by unprovoked sudden, brief disturbances in brain activity), and alcohol abuse.*His 4/15/25 Brief Interview for Mental Status (BIMS) assessment score was five, which indicated he had severe cognitive impairment.*His 4/15/25 elopement risk assessment indicated he was ambulatory, had a history of wandering, and had a high risk of wandering.*A 4/17/25 care plan focus area identified his elopement risk.-A 4/23/25 care plan intervention for WANDER ALERT: Staff to check [if his] wanderguard [Wanderguard, a wearable door alarming device] is functioning and working properly every night, had been updated on 7/15/25 with information identifying his Wanderguard number.*On 7/9/25, resident 14 had eloped, and the family and the physician had been notified.*On 7/9/25, Minimum Data Set (MDS) coordinator/registered nurse (RN) C, completed an assessment to verify there had been no injury, and neurological checks were completed as scheduled for 72 hours.*On 7/10/25, a medication review was completed with no changes recommended.*On 7/14/25, a care plan intervention had been added to Notify [the] charge nurse if he is pacing up and down the hallways to identify pattern of wandering. 3. Interview and review of documentation on 8/7/25 at 8:48 a.m. with DON B revealed:*She had been notified on 7/9/25 that resident 14 had eloped, and he had returned safely to the facility within about 30 minutes.*Education on elopement and wandering had been completed with all staff.-This was verified with employee sign-in sheets.*Monitoring and audits had been conducted for all residents who were at risk for wandering to ensure their assessments and care plans accurately reflected their needs.*Resident 14 was ambulatory and liked to walk. Interventions have been implemented using restorative therapy to provide him with more supervised opportunities to walk outside. 4. The provider implemented systemic actions to ensure the deficient practice does not recur was confirmed on 8/7/25 by having:*Initiated and documented one-hour checks on six residents, including resident 14, who wander or are at risk for wandering.*Reviewed all residents, identified those potentially at risk for elopement, and completed elopement risk assessments for those residents.*Provided education starting on 7/10/25, for all facility staff regarding resident wandering, elopement, policy revisions, and response to door alarm activations before their next worked shift.*Reviewed and updated care plan interventions for all residents at risk for elopement.*Reviewed and revised policies on elopement and wandering.*Initiated audits for new resident admissions for elopement risk to ensure appropriate interventions were implemented, and MDSs were completed to ensure care plans reflected the needs and concerns identified in the Care Area Assessments (care areas triggered for further evaluation based on MDS responses) (CAAs).*Initiated the above items into their Quality Assurance Program Improvement meeting on 7/31/25. Based on the above information, non-compliance at F689 occurred on 7/9/25, and based on the provider's 7/31/25 implemented corrective actions for the deficient practice confirmed on 8/7/25, the non-compliance is considered past non-compliance.