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F 000	INITIAL COMMENTS An extended complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/29/24 through 10/31/24. Areas surveyed included resident neglect related to trauma informed care and a resident who fell from a mechanical lift. Sanford Chamberlain Care Center was found not in compliance with the following requirements: F600, F657, and F699.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) 9/25/24 facility-reported incident (FRI), observation, interview, record review, and policy review, the provider failed to: *Ensure the physical and psychosocial wellbeing for one of one sampled resident (1) with a history of trauma expressed feelings of fear, feeling unsafe, and suicidal thoughts that potentially	F 600	Dementia Training was pushed out to all shared staff and will be reviewed by 11/29/24 or before next scheduled shift. DON or designee will monitor all new staff coming on and all current staff working for 6 months, then 3 random checks per month for three months checking that their Sanford learn is complete by DON or designee. Results will be reported to the monthly QAPI meeting x 6 months or until the committee deems necessary. All staff will be educated on the Abuse and neglect policy by 11/29/2024 or before thier next shift. DON or designee will monitor by signatures and check lists. Resident 2 has been a 1:1 while awake since 10/31/2024 and guardianship was obtained on 11/15/2024. DON or Designee will monitor per amount of MDS per week for 3 months and then 5 care plans per month x6 months. Results will be reported to the monthly QAPI meeting x 6 months or until the committee deems necessary.	11/29/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Erica Peterson	Administrator	11.20.24

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increased after an unwanted entry into her room and an act of physical aggression made towards her by resident (2) who has cognitive impairment.
*Ensure two of two sampled residents (2 and 3) were free from acts of verbal and physical aggression towards each other.
Findings include:

1. IMMEDIATE JEOPARDY NOTICE
Notice of immediate jeopardy was given verbally and in writing on 10/30/24 at 3:06 p.m. to administrator A and executive assistant K for F600 related to resident 1's fears and expressed suicidal thoughts following unwanted encounters with resident 2, lack of necessary interventions to keep resident 2 from entering other rooms and aggressing and maintaining separation of residents 2 and 3 to minimize verbal and physical aggression towards each other. A plan for removal of the immediacy was requested.

2. Review of the provider's 9/25/24 SD DOH FRI revealed:
*Resident 2 entered resident 1's room and a verbal altercation occurred.
*Resident 1 became scared "due to pass [past] personnel events earlier in her life."
*Resident 1 "has a trauma history and does not care for this resident [resident 2] who walked into her room."
*Regarding resident 2 "Medication has been restarted is aware of behaviors with behaviors getting better with medication adjustments".
-No other interventions to keep resident 1 safe were included in the FRI.

Observation on 10/29/24 at 2:17 p.m. of resident 2 revealed:
*He was in the commons area, walking with

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socks on his feet and no shoes.
-He was smiling and laughing, was able to say words, but his statements were nonsensical.

Observation on 10/29/24 at 2:43 p.m. of resident 2 revealed:
*He was in the kitchenette area and staff were able to redirect him to the commons area.
-He agreed to sit on the couch, was assisted to the couch, and then refused to sit down.
-He continued to attempt to enter the kitchenette.

Interview and observation 10/29/24 at 3:07 p.m. with resident 1 revealed:
*There was a "mental health therapist" who came to the facility, weekly, to counsel her.
-She had received counseling from that therapist for many years and felt it was very helpful.
-She stated, "She has dug me out of a hole more than once."
*When asked specifically about other residents she stated "that's a hard piece to chew" because some of them have hearing and vision deficits.
*When asked if she felt safe, she replied "no".
*She stated resident 2 had "tried to strangle me about a month ago", he came from behind and grabbed her neck with both hands and then let go and left.
-She demonstrated by placing both of her hands around her neck.
-She stated that she had not "provoked" him. She didn't know "what got into his head."
*He entered her room again on 9/25/24, she yelled at him, and he left after a short time.
-She stated, "I was so shaky it caused me to go to the hospital".
-She stated that she has been at the hospital before for severe depression, PTSD (Post Traumatic Stress Disorder),anxiety and "all that

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stuff".
*She stated, "He [resident 2] is still here so I don't think they have done anything" and the staff tell her it takes time.
*She had been instructed by the staff to push her call button, yell, or scream, when resident 2 came into her room.
-He has continued to come into her room, she tells him to leave, and he does.
*She stated, "I choose to stay in my room because I don't want any contact, I think he needs to go somewhere where he can get the proper attention."

Review of the provider's 8/1/24 SD DOH FRI revealed:
*On 7/31/24 resident 2 was "very agitated".
-He had a verbal altercation with resident 3.
-"Both men were separated into different ways. Recommendation: continue to monitor."
-No other interventions were included in the FRI.

Review of the provider's 10/15/24 SD DOH FRI revealed:
*On 10/15/24 resident 2 entered resident 3's room.
-Resident 2 was "yelling and swearing" at resident 3.
-Resident 3 reported resident 2 grabbed his forearms.
-There was no visible injury.

3. IMMEDIATE JEOPARDY REMOVAL PLAN
On 10/30/24 at 7:11 p.m. administrator A provided the survey team with a final written immediate jeopardy removal plan. The removal plan had been approved by the survey team on 10/31/24 at 8:32 a.m. with guidance from the assistant administrator and long-term care advisor for the

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F 600	Continued From page 4 South Dakota Department of Health. The provider gave the following acceptable immediate jeopardy removal plan on 10/31/24 at 10:30 a.m. 1. On 10/30/24 at 3:25 p.m. implemented one-to-one staff assistance for resident 2 to ensure his safety and residents 1 and 2's safety. 2. On 10/30/24 updated resident 2's care plan with the new interventions to keep residents 1 and 3 safe. 3. On 10/30/24 at 4:06 p.m. resident 2 was moved to the opposite household to limit interactions between residents 2 and 3. 4. On 10/30/24 at 4:23 p.m. resident 2's primary care physician was notified and an order for Rexulti and a second referral to psychiatric counseling was received. 5. On 10/30/24 at 5:19 p.m. a paper stop sign was placed next to resident 1 and 3's doorways to deter resident 2 from entering their rooms. 6. On 10/30/24 approximately 5:25 p.m. completed immediate education with all staff on duty. 7. On 10/30/24 at 5:34 p.m. emailed all staff resident 2's updated care plan. 8. On 10/30/24 at 6:16 p.m. texted all staff that they needed to read that email and care plan. The immediate jeopardy was removed on 10/31/24 at 10:30 a.m. after the survey team verified the provider had implemented their removal plan. After the removal of the immediate jeopardy, the scope and severity of the citation level was lowered to a G. Current census was 43. 4. Interview on 10/29/24 at 2:20 p.m. with housekeeper I revealed: *She felt resident 1 did not like resident 2	F 600		

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because, "He has choked her before" a couple of months ago.
-Resident 1 went to a psychiatric hospital as she was afraid of resident 2.
*Housekeeper I had no training regarding dementia and behaviors of residents.

Interview on 10/29/24 at 2:44 p.m. with licensed practical nurse (LPN) F revealed:
*"He [resident 2] "is very busy" and he wandered "quite a bit."
-He wandered into other resident rooms when he was not provided one-to-one assistance from staff.
-Other residents would get upset with resident 2.
-He would spend most of the day in the social service staff's office.
-He often became "worked up" and "anxious".
-She indicated that loud noises "triggered" his behaviors and would "set him off".
-He had a history of becoming physically abusive to staff.
-She was not aware if he had become physically abusive to other residents.
-She stated that resident 3 often "sets him off".
*She identified the following interventions for resident 2's behavior:
-Direct him to the social service staff office.
-A staff member was to spend one-to-one time with him.
-When he was exit seeking, a staff member was to walk with him around the facility.
*She knew that on 8/22/24 at 6:30 p.m. there was an incident between resident 2 and resident 1 but had no further knowledge of that incident.

Interview on 10/29/24 at 2:50 p.m. with CNA/CMA E revealed:
*Resident 2 and resident 3 had "gotten into it" but

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were now friends.
*Resident 2 would go into other residents rooms.
-A staff member would re-direct him out of the room.

Interview on 10/29/24 at 3:10 p.m. with activities supervisor H regarding resident 2 revealed:
*He had a short attention span.
*When she saw he was becoming agitated she would try to redirect him to a different area.
*A staff member was to have "eyes on him".
*Resident 3 "likes to antagonize" resident 2 to see his reaction.
-Resident 3 would call resident 2 names and would say "do you want to fight".

Interview on 10/30/24 at 8:35 a.m. with RN G regarding resident interactions revealed:
*Interventions for keeping resident 1 safe included that she stayed in her room or the activity room and she "can remove herself from the situation".
-Other interventions had included "notes on the doors", and to keep doors closed.
--There was no "note" observed resident 1's door.
*Interventions for keeping resident 2 safe were to keep him distracted and keep resident 2 and 3 separated.
*Any changes to interventions would be provided to her during nurse-to-nurse report with updated care plans.

Interview on 10/30/24 at 8:45 a.m. with CNA D regarding resident interactions revealed:
*She was aware of an incident between resident 1 and resident 2.
-She made sure resident 2 did not go into resident 1's room.
-When resident 2 went towards resident 1's room,

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she would make sure they were both safe.
*Interventions for keeping resident 2 safe were to monitor as able, intervene if needed, re-direct to keep them apart, and resident 3 was easier to redirect.

Interview on 10/31/24 at 11:19 a.m. with licensed social worker (LSW) C, administrator A, and director of nursing (DON) B via teleconference revealed:
*They had not reviewed the psychiatric hospital notes upon resident 1's return to the facility.
-They were not sure if anyone else had reviewed the notes.
-They would have expected the nurse on duty at the time of resident 1's return to review the notes and update the resident's EMR.

5. Review of resident 1's electronic medical record (EMR) revealed:
*She was admitted on 8/24/19.
*Her 8/23/24 Brief Interview of Mental Status (BIMS) assessment score was a 15, which indicated her cognition was intact.
*Her diagnoses included cerebral palsy, anxiety, depression, sleep disturbance, and heart disease.

Review of resident 1's nurses progress notes revealed:
*On 8/22/24 at 6:30 p.m., "Resident [1] informed CNA [certified nursing assistant/certified medication aide (CNA/CMA E)] of incident in her room with resident (2) entering her room while she was watching TV [television] and putting his hands on her shoulders by her neck and squeezing tightly. Resident [1] states she has pain but declines pain med [medication]."
"Resident [1] has no marks on her neck/shoulders at this time. Resident is calm but

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doesn't want this to happen again and wants to do what she can to make sure. Resident does seem fearful for her safety and the safety of others."
*On 8/22/24 at 8:47 p.m., "She [resident 1] informed me that she wanted to file a complaint with the city police. RN [registered nurse] did call [out of town] dispatch and police arrived at 2040 [8:40 p.m.] to get statement from resident."
*On 8/23/24 resident 1, "Stated she was shook but doing ok. She stated she feels safe most of the time just not safe now around the male resident [2]. She stated she avoids coming out of her room at night because of another resident."
*On 8/26/24, "She [resident 1] then made her own appointment to see her counselor [name] today at 11am [11:00 a.m.] She reported to the CNA that 'her mind is all over the place after what happened last week'."
*On 8/30/24, a care conference note indicated "she [resident 1] feels staff aren't doing anything about him and getting him out of the facility". "[Resident 1] did state will continue to stay in her room until he leaves facility or she is gone."
*On 9/4/24, "resident 1 wants to find another nursing home to live in because of resident [2]. She voices to staff that she feels like her rights have been taken away from her and that she does not want to be out of her room much. She states that she will go 'anywhere but here'."
*On 9/25/24, "Resident [1] upset that another resident [2] took a step into her room while walking down the hallway with a CNA. [Resident 2] did not fully go into room. Resident was using bathroom at the time and door was half closed. CNA quickly direct [resident 2] back into the hallway."
*On 9/26/24 at 9:11 a.m., Resident 1 reported to "Dakota at Home" (South Dakota's aging and

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disability resource center) an incident. "This RN spoke with resident [1] who states she was in her bathroom getting ready for bed at" "and was halfway undressed when resident [2] came into her room". "RN asked if resident [1] was physically harmed and she denied but stated she was mentally harmed." "Resident [1] states she 'wants the hell out of this place'." "Resident [1] stated that she is tired of the run-a-round, that he's [resident 2] is supposed to be on a 24 hour watch and how does he get into her room twice." "she stated she feels like she has no rights and that he shouldn't even be here. Resident [1] held up her thumb and fore-finger tightly together and said 'I'm this close to committing suicide.' She said she shouldn't have to stay in her room for 3 weeks". "Resident [1] is frustrated and states feels like she isn't important and that she doesn't matter."
*On 9/26/24 at 4:09 p.m., resident 1 was transferred to a psychiatric inpatient hospital. "This RN talked to resident [1] prior to leaving and resident states she still feels the same urge for suicide and denies having any methods to carry out thoughts."
*On 10/10/24 at 4:15 p.m., resident 1 returned to the facility from the psychiatric inpatient hospital.
*On 10/21/24, resident 1 reported that "[resident 2] had been in her room x2 [two times] this morning."

6. Review of resident 2's electronic medical record (EMR) revealed:
*His diagnoses included: dementia without behavioral disturbances, psychotic disturbance, mood disturbance, and anxiety; Alzheimer's Disease, Parkinson's disease, pain in right shoulder, and conduct disorder.
*His 9/4/24 primary care provider progress notes

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included:
-"There have been a lot of changes over the past couple months. Per state requirements we took him off all antipsychotic medications as his diagnosis did not meet their recommendations. As a result, the patient's behaviors became significantly worse to the point of threatening physical harm to other residents in long-term care."
-"A lot of his issues depend on who is working and how they are able to handle him, however, there is some room for improvement as he is not as good as he used to be."

Review of resident 2's nurses progress notes included:
*On 10/17/24 resident 3 stopped beside resident 2 who was sitting quietly at the nurses station.
-Resident 3 stated, "I should just smack him now".
-Resident 2 yelled at resident 3.
-Resident 3 then "started punching [resident 2] in the upper left arm.
-Resident 2 grabbed at resident 3 and started to swing and punched him in the arm.
-Staff intervened and separated the residents.
-Resident 2 had no noted injuries.
-It was documented that resident 3 stated "he did not get hit" and denied pain to his fist from hitting resident 2.
-He then stated that, "I want to hit him again and again" as he laughed.
-There were no other documented interventions to ensure the safety of resident 2 or resident 3.

7. Review of resident 3's EMR revealed:
*His diagnoses included: Tourette's disorder (a chronic nervous system condition that causes people to have involuntary tics, or repetitive

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movements and sounds, that they cannot control), depression, and nicotine dependence.
*His 8/16/24 BIMs score was a 10, which indicated he was cognitively impaired.

Review of resident 3's nurses progress notes revealed:
*There was no progress note regarding the 7/31/24 altercation with resident 2.
*On 8/13/24 he was calling two other residents, "Coo-Coo" and stated, "I don't have to be nice, I pay enough, to live here, and then [they] don't even know/understand I'm [I am] even calling then names."
*He had physical altercations with resident 2 on 10/15/24 and on 10/17/24.
*His 10/25/24 primary care provider progress note revealed:
-He had a history of cognitive impairment.
-"He is due to see Behavioral Health as he does have some outbursts that are slightly inappropriate at times. Behavior Health is due to see him on 12/4 [12/4/24]."

8. Review of the provider's 6/30/23 Abuse Prevention policy revealed:
*"Purpose:"
-"To identify, correct, and intervene in situations in which abuse, neglect, or misappropriation of residents' property is more likely to occur."
-"Physical Abuse: includes, hitting, slapping, pinching, kicking, etc."
-"Psychosocial Abuse: includes, but is not limited to, humiliation, harassment, threats of punishment, deprivation, restraints, silence, or exposing."
-"Neglect: a failure, through inattentiveness, carelessness, seclusion, or omission, without a reasonable justification to provide timely,

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SANFORD CHAMBERLAIN CARE CENTER	300 S BYRON BLVD CHAMBERLAIN, SD 57325

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12 consistent and safe services, treatment and care to a resident." *"Procedure:" -"Administration and Head of Dept. [Department] will provide a plan to correct and intervene in situations identified that abuse is more likely to occur:" -"The assessment, care planning, and monitoring of the resident needs and behaviors which might lead to conflict or neglect, such as aggressive behaviors, wandering, self-injurious behaviors, communication disorders, and residents requiring high levels of care or are totally dependent."	F 600		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657	Education was provided to the DON and LSW by the administrator on the importance of care plans being up to date and reviewed care plan policy on 10/31/2024. Lift policy will be given to all direct care staff and reviewed and signed by 11/29/2024 or before next scheduled shift. Care plans will be monitored by DON or designee per amount of MDS per week for 3 months and then 5 care plans per month x6 months. Results will be reported to monthly QAPI meeting x 6 months or until committee deems necessary.	11/29/2024

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or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
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 care plans were reviewed and revised for four of four sampled residents (1, 2, 3, and 4). Findings include:

1. Review of the provider's 8/13/24 submitted SD DOH FRI regarding resident 4 revealed:
*On 8/12/24 at 10:00 a.m. resident 4 slid out of the stand aid lift (a manual lift used to assist from a seated to a standing position) while being transfered to her wheelchair.
-Certified nursing assistant (CNA) K assisted resident 4 with the transfer.
--No other staff member was present.
-The provider reported that CNA K followed resident 4's plan of care by using the stand aid but she had not followed the provider's policy for two staff members being required for transfers with the use of a stand aid.
-Resident 4 was not injured from the fall.
-The report indicated that one to one education was provided to CNA K immediately after the fall.

Interview on 10/29/24 at 2:30 p.m. with resident 4 regarding the above fall revealed:
*She was able to recall the incident and stated she was not injured.
*She indicated there were "usually two" staff members assisting her when they used the lift.
-She stated one person had assisted her when

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using the lift "hardly at all".

Interview on 10/29/24 at 2:50 p.m. with certified nursing assistant/certified medication aide (CNA/CMA) E regarding transfers revealed:
*Resident 4 is currently a full body mechanical lift (a mechanical lift and sling used to lift a person's full body) due to her recent surgery, which resulted in her having weight limitations to her left upper extremity.
*CNA/CMA E reported that two staff were required to assist with all lift transfers.
-When asked how long the use of two staff had been required, she stated it "had always been that way."
*CNA/CMA E stated that she was of the understanding that resident 4 fell during a transfer because she let go of the handles.
-CNA/CMA E stated it was not "normal" for resident 4 to let go of the handles.

Interview on 10/30/24 at 8:35 a.m. with registered nurse (RN) G during review of resident 4's care plan revealed:
*RN G used the care plans to determine what cares need to be provided for residents.
-Changes in care plans were relayed to staff through nurse to nurse report, nurse to CNA report and care plan updates.
*When asked how resident 4 was to be transfered, RN G stated that she had used a full body mechanical lift since her surgery.
-She reviewed resident 4's 10/30/24 care plan and indicated that on 3/15/24 she was "changed to a stand-aid for transfers, hoyer [full body mechanical lift] as needed."
*RN G indicated if she was a new staff member, that referred to the care plan, she would have transferred resident 4 with a stand aid.

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Interview on 10/30/24 at 8:45 a.m. with CNA D during review of resident 4's care plan revealed:
*CNA D used the care plans tp determine what cares residents required.
*Updates and communication were provided to her during report from the nurse.
*CNA D indicated resident 4 used a full body mechanical lift for transfers.
*After reviewing resident 4's care plan, CNA D confirmed the care plan instructed staff to transfer resident 4 with a stand aid and a full body mechanical lift could be used as needed.
-She indicated as needed to her meant if resident 4 was "weak or sick."
-CNA D stated, "If it [the transfer information on the care plan] is not the most recent, they would have it out of there, right?"

Review of resident 4's electronic medical record (EMR) revealed:
*Resident 4 had a left mastectomy (surgical breast removal) on 9/26/28 and returned to the facility on 9/28/24.
*Her current care plan included, she "requires extensive assist x2 [with two staff members] for transfers using a Hoyer [full body mechanical] lift d/t [due to] increased weakness to lower & [and] upper extremities. 3/15/24 switched back to stand-aid for transfers, hoyer [full body mechanical lift] as needed."
2. Observation on 10/29/24 at 2:17 p.m. of resident 2 revealed:
*He was in the commons area, walking with socks on his feet and no shoes.
-He was smiling and laughing, was able to say words, but his statements were nonsensical.

Observation on 10/29/24 at 2:43 p.m. of resident

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2 revealed:
*He was in the kitchenette area and staff were able to redirect to the commons area.
-He agreed to sit on the couch, was assisted to the couch, and then refused to sit down.
-He continued to attempt to enter the kitchenette.

Interview on 10/29/24 at 2:20 p.m. with housekeeper I regarding resident 2 revealed:
*He had "choked" a resident a couple of months ago.
*He had "hit" a staff member.

Interview on 10/29/24 at 2:44 p.m. licensed practical nurse (LPN) F regarding resident 2 revealed:
*He wandered into other resident rooms.
-Other residents would get upset with resident 2.
-She was not aware if he had become physically abusive to other residents.
-He often became "worked up" and "anxious".
-Resident 3 often "sets him off".
-He had an altercation with resident 1 on 8/22/24.
*She identified the following interventions for resident 2's behavior:
-Direct him to the social service staff office.
-A staff member to spend one-to-one time with him.
-When he was exit seeking, a staff member was to walk with him around the facility.
*He was physically abusive to staff.

Interview on 10/29/24 at 2:50 p.m. with CNA/CMA E revealed:
*Resident 2 would go into other residents rooms.
-A staff member would re-direct him out of the room.
*Resident 2 and resident 3 had "gotten into it" but were now friends.

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Review of resident 2's EMR revealed:
*He was admitted on 7/25/23.
*His 9/27/24 Brief Interview of Mental Status (BIMS) assessment score was 0, which indicated he had severe cognitive impairment.
*His October 2024 medication administration record (MAR) included an 7/25/23 physician order for acetaminophen [Tylenol] PRN [as needed].
-He received the PRN acetaminophen once on 10/1/24.
*His care plan included:
-Staff members proper names.
--One of those staff members was no longer employed.
-Had a problem area listed as "pain" with interventions of "Tylenol scheduled & [and] PRN."
-Regarding wandering into other residents rooms his interventions included to "Remove resident from other resident's rooms and unsafe situations."
--There were no interventions to prevent him from entering other residents rooms.
-An 8/2/23 care plan problem indicated, "exhibits wandering (moves with no rational purpose, seemingly oblivious to needs or safety) r/t [related to] his dementia putting him at risk for elopement."
--The interventions that staff were utilizing for his wandering and behaviors were not identified in his care plan.
-There was no mention of him being physically and verbally aggressive with residents or staff.

3. Interview on 10/29/24 at 2:44 p.m. with LPN F regarding resident 2 revealed resident 3 often "sets him off".

Interview on 10/29/24 at 2:50 p.m. with CNA/CMA

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E revealed resident 2 and resident 3 had "gotten into it" but were now friends.

Review of resident 3's EMR revealed:
*He was admitted on 6/24/22
*His 8/16/24 BIMs assessment score was 10, which indicated he was moderately cognitively impaired.
*His care plan had not included his aggression and targeting of another male resident.

4. Interview and observation 10/29/24 at 3:07 p.m. with resident 1 revealed:
*There was a "mental health therapist" who came to the facility, weekly, to counsel her.
-She stated, "She has dug me out of a hole more than once."
*She stated she did not feel safe due to resident 2 had "tried to strangle me about a month ago", he came from behind and grabbed her neck with both hands and then let go and left.
*She indicated resident 2 again entered her room on 9/25/24 and she stated, "I was so shaky it caused me to go to the hospital".
-She had been hospitalized for severe depression, post-traumatic stress disorder (PTSD), anxiety and "all that stuff".
*She had been instructed by the staff to push her call button, yell, or scream, when resident 2 came into her room.
*She stated, "I choose to stay in my room because I don't want any contact."

Interview on 10/30/24 at 9:00 a.m. with licensed social worker (LSW) C regarding the care needs of resident 1 revealed:
*Resident 1 had a history of PTSD related to being tormented as a child for having cerebral palsy (neurological disorder that affects

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movement and posture, caused by damage to or abnormalities inside the developing brain).
-Resident 1 had a safety plan for suicide prevention interventions that was detailed on a "card" that she only shared with staff she trusted.
*LSW C was responsible for developing and maintaining residents' mood and behavior care plans.

Review of resident 1's EMR revealed:
*She was admitted on 8/24/19.
*Her 8/23/24 BIMs assessment score was a 15, which indicated her cognition was intact.
*Her diagnoses included cerebral palsy, anxiety, depression, sleep disturbance, and heart disease.
*She had an inpatient psychiatric hospitalization stay from 9/26/24 through 10/10/24, that documentation indicated:
-She had suicidal ideation with "thoughts of stabbing or cutting herself with knives and refusing to leave her room."
*Her 10/30/24 care plan included that she was on "Wellbutrin and Estazolam doses d/t [due to] increase depression & [and] Anxiety with positive suicidal ideations without plan or intent or means."
*Her care plan had not included she:
-Had a safety plan for suicide prevention interventions.
-Had a history of PTSD.
-Received psychiatric care from a counselor on a weekly basis.
-Was vulnerable and at risk for physical abuse and psychosocial trauma from a male resident.

5. Interview on 10/31/24 at 11:19 a.m. with LSW C, administrator A and director of nursing (DON) B revealed:
*Minimum Data Set (MDS) nurse M was

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responsible for the completion of the residents' care plans.
-DON B was responsible when MDS Nurse M was not available.
-A remote corporate MDS nurse also assisted when necessary.
*Their expectation was "what the regulation is".
*LSW C stated care plan updates were to be completed quarterly with the MDS and whenever there was a change of care need, examples given were the use of a lift or a pressure ulcer.
-She confirmed care plans should be consistent with the current care a resident required.
*DON B confirmed she had updated resident 4's care plan on 10/31/24 to include the use of a full body mechanical lift only, she was not aware the care plan still had two areas where the lift use was not accurate.
*Regarding resident 2's care plan:
-DON B stated resident 2 did not have obvious pain.
-DON B indicated the proper names of staff would be removed from his care plan.
*LSW C confirmed resident 3's behaviors of targeting other residents was not included in his care plan.
*LSW C confirmed resident 1's care plan did not include her suicidal ideations, PTSD, or her safety plan.

6. Review of the provider's 6/10/24 Dementia Care Guidelines policy revealed:
*"Behavioral expressions or indications of distress often represent a resident's attempt to communicate an unmet need, discomfort or thoughts they can no longer articulate."
*"All behavior has meaning and is a means to communicate an unmet need." A resident's distress may be related to a variety of factors,

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including physical needs, emotional needs, the environment or actions of the caregiver. Possible causes include:
-a. Physical Health:
-b. Emotional: Fear, anxiety, boredom, insecurity, lack of choice or control which may result in flight or fight responses and are not uncommon emotions for residents with dementia when their emotional needs are unmet."
-c. Environment: They key to a positive environment for residents with dementia is to manage stimulation in the environment. Changes in the environment or too much stimulation such as too many people, too much noise, inadequate lighting levels and lack of structure, routine, and/or activities can cause challenging behaviors."
*"Residents with dementia may exhibit behaviors that are unpredictable due to brain changes. Utilize individualized, non-pharmacological approaches for behaviors since there is no magic pill to eliminate behaviors."

7. Review of the provider's 11/16/23 Trauma Informed Care policy revealed:
*"Trauma - 'Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has a lasting adverse effect on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."
*"Trauma-informed care - 'is a strength-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.'"

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F 657	Continued From page 22 *"Document how trauma is currently affecting resident." *"Individualize Care Plan interventions to avoid re-traumatization;" 8. Review of the provider's 11/1/23 Care Plan policy revealed: *"Person-centered care - A focus on the resident as the locus of control and supporting the resident in making his or her own choices and having control over their daily life." *"Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment." -"Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through the use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders." *"The plan of care will be modified to reflect the care currently required/provided for the resident." *"The interdisciplinary team will review care plans at least quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition."	F 657		
F 699 SS=G	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent,	F 699	Trauma informed care assessment will be completed on admission, quarterly or any significant change. Psych Consult for residents who seem to be experiencing a crisis outside of thier "normal" will be obtained in a timely manner. (Continued next page)	11/29/2024

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F 699	Continued From page 23 trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview, and policy review, the provider failed to ensure: *One of three sampled residents (1) had been screened for post-traumatic stress disorder (PTSD) upon admission, quarterly, annually, or upon her return from an inpatient psychiatric hospitalization for suicidal ideations. *Two of three sampled residents (2, and 3) had been screened for post-traumatic stress disorder (PTSD) upon admission, quarterly, or annually. Findings include: 1. Interview on 10/30/24 at 3:07 p.m. with resident 1 revealed: *There was a "mental health therapist" who came to the facility, weekly, to counsel her. -She had received counseling from that therapist for many years and felt it was very helpful. -She stated, "She has dug me out of a hole more than once." *She stated she had been hospitalized for severe depression, PTSD, anxiety and "all that stuff". Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on 8/24/19. *Her 8/23/24 Brief Interview for Mental Status (BIMs) assessment score was 15, which indicated her cognition was intact. *There was no trauma screen completed upon admission, quarterly, annually, or upon her return from an inpatient psychiatric hospitalization.	F 699	All trauma informed care assessments for each resident will be completed by 11/29/2024 by LSW. Education was provided by the DON to LSW and LSW read and signed the Trauma Informed Care Policy on 11/18/2024. DON or designee will review all new admission for trauma assessment charting x 3 months and 2 residents' charts per month x 6 months. Results will reported to the QAPI monthly meeting x 6 months or until committee deems necessary.	11/29/24

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*She had an inpatient psychiatric hospitalization stay from 9/26/24 through 10/10/24, that record indicated:
-She had suicidal ideation with "thoughts of stabbing or cutting herself with knives and refusing to leave her room."
-She had PTSD related to the abuse her first husband inflected.

2. Review of resident 2's EMR revealed:
*He was admitted on 7/25/23.
*His 9/27/24 BIMs assessment score was 0, which indicated he had severe cognitive impairment.
*There was no trauma screen completed, or documentation that he was unable to complete one.

3. Review of resident 3's EMR revealed:
*He was admitted on 6/24/22.
*His 8/16/24 BIMs assessment score was 10, which indicated he was modertately cognitively impaired.
*There was no trauma screen completed upon his admission or on a quarterly basis.
*A yearly trauma screen had been completed for him on 6/19/23.
-There was no yearly trauma screen completed for him for 2024.

4. Interview on 10/31/24 at 11:19 a.m. with licensed social worker (LSW) C regarding trauma screening of residents revealed:
*She was responsible to screen all residents for trauma upon their admission, quarterly, annually, and with a significant change.
*She confirmed she had not completed a trauma screen for:
-Resident 1 upon her admission, quarterly,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CHAMBERLAIN CARE CENTER	300 S BYRON BLVD CHAMBERLAIN, SD 57325

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 25	F 699		

annually, or from her return from an inpatient psychiatric hospital.
-Resident 2 upon his admission, quarterly, or annually.
-Resident 3 upon his admission, quarterly, and annually for 2024.

5. Interview on 10/31/24 at 11:25 with director of nursing B regarding resident 1's recent psychiatric hospitalizaiton revealed:
*She had not reviewed the hospital notes upon resident 1's return.
-The nurse on duty was to have reviewed those notes.

6. Review of the provider's 11/16/23 Trauma Informed Care policy revealed:
*"Trauma - 'Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has a lasting adverse effect on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."
*"Trauma-informed care - 'is a strength-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.'"
*"The Trauma Assessment is required:
-a. Within five days of admission for all new residents;
-b. PRN [as needed].
*"The Trauma Assessment is completed by Social Services while interviewing the resident/representative."
*"Document how trauma is currently affecting

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	43A073	A. BUILDING _____ B. WING _____	C 10/31/2024

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F 699	Continued From page 26	F 699		

resident."
*"Individualize Care Plan interventions to avoid re-traumatization;"
*"See Also".
-"SAMHSA's [Substance Abuse and Mental Health Services Administration] - Concept of Trauma and guidance for a Trauma-Informed Approach".
-"SASMHSA - Trauma-Informed Care in Behavioral Health Services: Quick Guide for Clinicians Based on Tip 57".

Review of the SAMHSA's July 2014 Concept of Trauma and guidance for a Trauma-Informed Approach revealed:
*"A trauma-informed approach seeks to resist re-traumatization of clients as well as staff."
*"A trauma-informed approach reflects adherence to six key principles".
-"1. Safety: Throughout the organization ...feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety."
*"Trauma screening and assessment are an essential part of the work. Trauma specific interventions are acceptable, effective, and available for individual ...seeking services."

Review of the SASMHSA's 2014 Trauma-Informed Care in Behavioral Health Services Based Quick Guide for Clinicians Based on Tip 57 revealed:
*"Create a Safe Environment".
*"Conduct Universal Routine Trauma Screening".
*"The most important areas to screen among individuals with trauma histories include:
-Trauma-related symptoms.
-Depressive symptoms.
-Sleep disturbances.

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F 699	Continued From page 27 -Past and present mental disorders, including trauma-related disorders. -Type and characteristics of trauma. -Substance abuse. -Social support, coping styles, and availability of resources. -Risks for self-harm, suicide, and violence. -Health screenings." *"A positive screening calls for further action-an assessment that evaluates presenting struggles to develop an appropriate treatment plan and to make an informed and collaborative decision about treatment placement." *"Establish Safety". *"Prevent Retraumatization". -"Be sensitive to the needs of clients who have experienced trauma; consider behaviors in the treatment setting that might trigger memories of the trauma." *"Address Sleep Disturbances and Disorders".	F 699		