STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49736	A. BUILDING: _____ B. WING _____	C 02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD SPEARFISH SENIOR LIVING LLC	540 FALCON CREST DRIVE SPEARFISH, SD 57783

(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) COMPLETE DATE
S 000	Compliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 2/11/25. Areas surveyed included elopement and nursing services. Edgewood Spearfish Senior Living LLC was found not in compliance with the following requirements: S030 and S337.	S 000		
S 030	44:70:01:07 Reports To The Department Each facility shall report the following events to the department through the department's online reporting system within twenty-four hours of the discovery of the event: (1) An attempted suicide; (2) Any cause to suspect abuse or neglect of a resident; (3) Any death resulting from other than natural causes that originated on facility property; (4) A missing resident; (5) A fire in the facility; (6) Any loss of utilities, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than twenty-four hours; or (7) Any unsafe drinking water samples, or samples from pools or spas. The facility shall conduct an internal investigation for the event and report the results to the department no later than five working days after the event. The department may request additional information from the facility and investigate any reported event.	S 030		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 030	Continued From page 1 This Administrative Rule of South Dakota is not met as evidenced by: Based on a South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to: *Investigate three elopements (a resident left without staff knowledge) by one of one sampled resident (1). *Report to the SD DOH two elopements by one of one sampled resident (1). Findings include: 1. Review of the provider's 1/7/25 FRI submitted to the SD DOH by clinical services director (CSD)/registered nurse (RN) B revealed: *"Resident [1] was wearing a jacket, per his usual" and "was uninjured" when he was brought back inside of the facility by a transport driver who had observed the resident in the parking lot. "The resident had been outside for short time, less than half [an] hour." *The corrective action plan according to the FRI was: "Resident now has a Tempo." That "enables us to use geofencing on the Tempo device." -That corrective action plan contradicted CSD/RN B's 1/7/25 progress note that had stated the resident was already wearing a Tempo wristband. *Neither the FRI nor the above progress note had explained: -How it was determined resident 1 was outdoors "less than a half hour." -When resident 1 was last seen by staff, where he was, and what he was doing before the elopement, or if there had been any factors that had contributed to the elopement. -Why only the transport driver was interviewed regarding the incident. -If the resident's medical provider had been	S 030		

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S 030	Continued From page 2	S 030		

notified of the elopement.
-How it was determined the resident "was uninjured" after the elopement.

CSD/RN B was not available on the day of the survey to have been interviewed.

Review of resident 1's electronic medical record (EMR) revealed:
*A 1/7/25 progress note that was documented by clinical services director (CSD)/registered nurse (RN) B:
-Resident 1 "was outside getting in & out of employees cars. Informed that resident stated he was looking for his car & that resident was easily directed back into our building."
-It was discovered "resident [1] had taken his Care Predict Tempo device [a wristband worn by a resident that detects changes in that resident's daily activity and behavior patterns] off while in his room, so there was no alert when resident left the building."
-"...geofencing [technology that created a virtual geographic boundary that activated an alert when the Tempo wristband identified the resident had entered or left a particular area] can be set up on resident's Tempo for better monitoring of resident's whereabouts."

2. Continued review of resident 1's EMR revealed:
*A 1/30/25 progress note documented by assistant CSD/RN C:
-"Resident [1] outside walking around. Resident was seen coming in the side entrance (employee entrance) with an employee." "I asked resident if he was wearing his Tempo, and he showed me it was on. When I asked which door he walked out of, he said the front." "Resident is now on geofencing..."

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S 030	Continued From page 3 Interview on 2/11/25 at 1:30 p.m. with assistant CSD/RN C revealed: *She had not reported resident 1's 1/30/25 elopement to the SD DOH but she was expected to have done so. *She confirmed resident 1 was wearing his Tempo wristband at the time of his 1/30/25 elopement but the "geofence was not yet started." *It was her understanding the Tempo wristband should have alerted staff that resident 1 had exited the front door on 1/30/25. She had not investigated why it had not alerted. *Assistant CSD/RN C had not documented: -Any staff interviews to have known the last time the resident was seen before he eloped, where he was, and what he was doing before the elopement, or if there had been any factors that had contributed to the elopement. -How long the resident had been outdoors before he was brought in by staff. -If the resident's medical provider had been notified of the elopement. -An assessment of the resident's physical condition after that elopement. 3. Continued review of resident 1's EMR revealed: *A progress note completed on 2/7/25 by CSD/RN B: -"Resident [1] was found outside by CMA [certified medication aide] entering the building. Resident was very easily redirected back into the building." *CSD/RN B had not documented: -If the resident was wearing his Tempo wristband or if the geofence was operational. -Any staff interviews to have known the last time the resident had been seen before the elopement, where he was, and what he was	S 030		

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S 030	Continued From page 4	S 030		

doing before the elopement, or if there had been any factors that had contributed to the elopement.
-How long the resident had been outdoors before he was brought in by staff.
-If the resident's medical provider had been notified of the elopement.
-An assessment of the resident's physical condition after that elopement.

Interview on 2/11/25 at 1:10 p.m. with administrator A regarding resident 1's elopements revealed:
*She confirmed the SD DOH had not been notified of resident 1's 1/30/25 and 2/7/25 elopements.
-Either CSD/RN B or assistant CSD/RN C should have submitted those reports but they had not.
*Elopement investigations were to be documented on either the FRI form or in a progress note format.
-She agreed the 1/7/25 FRI and the above 1/7/25, 1/30/25, and 2/7/25 progress notes had not reflected complete investigations of resident 1's three elopements had occurred.
*She confirmed a documented nurse assessment was expected to have been completed for any resident following an elopement.

Review of the provider's January 2025 Elopement Risk Prevention/Missing Resident policy revealed:
*Document in the resident record:
-"a. Circumstances and precipitating factors.
b. Interventions utilized to return the resident to the unit.
c. The resident's response to the interventions.
d. Results of reassessment upon the resident ' s return and the condition of the resident.
e. Care rendered.
f. Notification of law enforcement, physician, family, management, Regional Nursing Directors,

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S 030	Continued From page 5 Regional Vice Presidents, and the appropriate agency per state requirements. g. Physician orders following notification. h. Additional prevention strategies implemented."	S 030		
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on a South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, job description review, and policy review, the provider failed to ensure: *One of one clinical services director (CSD)/registered nurse (RN) (B) or one of one assistant CSD/RN (C) had assessed and documented one of one sampled resident's (1) physical condition after three of three elopements. *Routine testing of one of one sampled resident's (1) Care Predict Tempo wristband to ensure it had alerted staff when he had gone beyond the boundaries of particular identified areas of the facility. Findings include: 1. Review of the provider's 1/7/25 FRI submitted to the SD DOH by CSD/RN B revealed: *"Resident [1] was wearing a jacket, per his usual" and "was uninjured" when he was brought back inside of the facility by a transport driver who had observed the resident in the parking lot. "The	S 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49736	A. BUILDING: _____ B. WING _____	C 02/11/2025

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S 337	Continued From page 6	S 337		

resident had been outside for short time, less than half [an] hour."
-There was no documentation that supported how it was determined the resident "was uninjured."

Review of resident 1's electronic medical record (EMR) revealed:
*No documentation that CSD/RN B had completed an assessment of resident 1's physical condition after the 1/7/25 elopement.
-The outdoor temperature on that day was expected to have been less than zero degrees Fahrenheit.

2. Continued review of resident 1's EMR revealed:
*A progress note completed on 1/30/25 by assistant CSD/RN C:
-"Resident [1] outside walking around. Resident was seen coming in the side entrance (employee entrance) with an employee."
*There was no indication of what the outdoor temperature was that day, how long the resident had been outdoors unaccounted for, and what the resident was wearing when he was brought back inside of the building after an employee had found him.
-There was no documentation that assistant CSD/RN C had completed an assessment of resident 1's physical condition after the 1/30/25 elopement.

3. Continued review of resident 1's EMR revealed:
*A progress note completed on 2/7/25 by CSD/RN B:
-"Resident was found outside by CMA [certified medication aide] [who was] entering the building. Resident was very easily redirected back into the building."

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S 337	Continued From page 7 -There was no indication of what the outdoor temperature was that day, how long the resident had been outdoors unaccounted for, and what the resident was wearing when he was brought back inside of the building after an employee had found him. *There was no documentation that CSD/RN B had completed an assessment of resident 1's physical condition after the 2/7/25 elopement. -The predicted temperature on 2/7/25 was expected to have been between one and eight degrees Fahrenheit. 4. Review of resident 1's EMR revealed: *A 1/7/25 progress note completed by CSD/RN B regarding resident 1's elopement that same day: -It was discovered "resident [1] had taken his Care Predict Tempo device [a wristband worn by a resident that detected changes in that resident's daily activity and behavior patterns] off while in his room, so there was no alert when resident left the building." -"...geofencing [technology that created a virtual geographic boundary that activated an alert when the Tempo wristband identified the resident had entered or left a particular area] can be set up on resident's Tempo for better monitoring of resident's whereabouts." Review of the 1/7/25 FRI submitted by CSD/RN B to the SD DOH regarding resident 1's elopement revealed the corrective action plan for that incident was: "Resident now has a Tempo." That "enables us to use geofencing on the Tempo device." CSD/RN B was not available on the survey date to have been interviewed. 5. Continued review of resident 1's EMR	S 337		

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S 337	Continued From page 8	S 337		

revealed:
*A 1/30/25 progress note completed by assistant CSD/RN C regarding resident 1's elopement that same day:
-"Resident [1] outside walking around. Resident was seen coming in the side entrance (employee entrance) with an employee." "I asked resident if he was wearing his Tempo, and he showed me it was on. When I asked which door he walked out of, he said the front." "Resident is now on geofencing..."

Interview on 2/11/25 at 1:30 p.m. with assistant CSD/RN C regarding resident 1's 1/30/25 elopement revealed:
*She confirmed resident 1 was wearing his Tempo wristband at the time of that elopement but the "geofence was not yet started."
-It was her understanding the Tempo wristband should have alerted staff that resident 1 had exited the front door on 1/30/25 but she had not investigated why it had not alerted.

6. Continued review of resident 1's EMR revealed:
*A 2/7/25 progress note completed by CSD/RN B:
-"Resident [1] was found outside by CMA [who was] entering the building. Resident was very easily redirected back into the building."
*Resident 1 was wearing his Tempo wristband at the time of that elopement. There was no indication if the geofencing function had alerted staff when the resident had exited the facility.

Interview on 2/11/25 at 1:15 p.m. with clinical care coordinator (CCC) D and administrator A regarding the Tempo wristband and the use of geofencing to mitigate the risk of resident 1's elopements revealed:
*The use of the Care Predict system (including

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	49736	A. BUILDING: _____ B. WING _____	C 02/11/2025

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S 337	Continued From page 9	S 337		

the Tempo wristband and geofencing option) had been implemented "a few months ago."
-A company representative had been on-site to provide staff training, but the facility was still learning all the functions of the system.
*Neither administrator A or CCC D had known on what date resident 1's Tempo wristband was first paired with the geofencing function to have alerted staff when he was exit-seeking.
-CCC D was able to determine that alerts had been activated on 1/21/25, 2/1/25, 2/3/25, and 2/10/25. That suggested resident 1 had made elopement attempts on those dates.
*Those above dates had suggested that:
-It had taken two weeks between resident 1's first elopement attempt (1/7/25) and the first known alert (1/21/25) for the facility to have implemented their plan of correction to prevent further elopement attempts.
--Administrator A agreed that was too long to have waited for that plan to have been initiated.
-No one had investigated why the Tempo wristband had not alerted staff on 1/30/25 and again on 2/7/25 while he was wearing it and eloped.
*Administrator A confirmed the facility did not have a system in place to have routinely tested the Tempo wristband to ensure it alerted staff when it had gone beyond the geofenced areas.
*Administrator A had not known the Tempo wristband and geofencing had worked hand-in-hand. The wristband alone was not capable of alerting staff to a possible elopement without the geofencing having been functional.

Review of the provider's January 2025 Elopement Risk Prevention/Missing Resident policy revealed:
*C. Intervention when a resident is found:
-The resident is examined for injuries.
*D. Documentation:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49736	A. BUILDING: _____ B. WING _____	C 02/11/2025

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S 337	Continued From page 10 -"d. Results of reassessment upon the resident's return and the condition of the resident. e. Care rendered." Review of the provider's May 2021 CSD and the January 2018 assistant CSD job descriptions revealed both positions were "responsible for the nursing process including assessment, analysis, planning, intervention, and evaluation of resident care according to [the] Nurse Practice Act, Edgewood policy and accepted company standards of practice." Refer to S030.	S 337		