STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66437	A. BUILDING: Pierre B. WING all	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PIERRE LLC	1950 EAST FOURTH STREET PIERRE, SD 57501

(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 3/4/24. The area surveyed was resident neglect. Edgewood Pierre LLC was found not in compliance with the following requirement: S337.	S 000	S 337 An all clinical staff meeting will be held on 3-28-2024 and the staff will be educated on the importance of taking the vital signs, the documentation of those vital signs in the EMR, and how to document "unscheduled" vital signs.	
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 record review, interview, observation, and policy review the provider failed to ensure *One of six sampled residents (1) had nursing instructions followed for obtaining vital signs and timely medical treatment related to her abnormal blood pressure and heart rate. *Three of six sampled residents (1, 2, and 3) had complete and accurate documentation in their care records. Findings include: 1. Review of resident 1's care record revealed: *On 1/15/24 at 4:45 a.m. she had a fall, and the on-call nurse was notified at 5:51 a.m. *Resident denied injury but did hit her head. *Staff assisted her back to bed with a wheelchair. *Her heart rate at the time of the fall was documented as 78 beats per minute. *Her blood pressure (BP) at the time of the fall was documented as 135/35. *The nurse had instructed the unidentified	S 337	Will assign R-Task LMS education on vital sign documentation and when to report to nurse. This will be monitored by the Clinical Services Director by auditing all incident reports weekly X 4 weeks and then Monthly X 4 Months. Finding of the Audit will be brought to the Director Meetings weekly X 4 weeks then Monthly x 4 Months and to our Quarterly QA meetings and discussed. Regional Nursing Director will provide education to all Nursing staff at Edgewood Pierre on the documentation expectations of documenting for incidents, change of condition, admissions, and discharges by 4-10-2024. RND will review documentation policy&get sing off of understanding.	4-10-24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Weyrich — TITLE: Executive Director — (X6) DATE: 3-22-2024

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S 337	Continued From page 1 unlicensed assistive personnel (UAP) to obtain vital signs every half hour times two, then hourly times three, and document the results in the care record. *The nurse instructed the UAP to call again if the following occurred: -Systolic blood pressure (first number) was less than 90 or greater than 180. -Diastolic blood pressure (the second number) was less than 60 or greater than 90. -The heart rate was less than 60 or greater than 100 beats per minute. *On 1/15/24 at 6:49 a.m. the on-call nurse was notified by the UAP that the resident had no changes or head pain, but her BP was 125/38 and her heart rate was 32 beats per minute. *The nurse gave instructions to recheck the vital signs per protocol. *There were no other vital signs documented in the care record. *On 1/15/24 at 7:45 a.m. the resident was being assisted to the toilet when she became weak and needed to sit down. Staff had to lower her onto the floor in her bathroom. *A nurse was in the facility at that time and was called to the resident's room. *The nurse documented "Significant bradycardia (slow heart rate) and low diastolic blood pressure noted." *Resident 1 had a lump on the back of her head, and was transported to the hospital by ambulance. *The residents family was not notified of resident's change in condition until after she was lowered to the floor. 2. Review of resident 2's care record revealed: *On 10/27/23 at 4:53 p.m. clinical services director (CSD) B documented the resident had two falls on 10/26/23.	S 337	This will be monitored by the Clinica Services Director weekly X 4 weeks then monthly for 4 months. She will monitor the documentation of the incidents, change of conditions, admissions and discharges. These findings will be brought to Director Meetings Weekly x 4 weeks then Monthly X 4 months and will be brought to quarterly QA meetings.	

Jennifer Weyrich

Executive Director 3-22-2024

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 337	Continued From page 2 *Review of the resident's nurse's notes only contained documentation for one fall that occurred on 10/26/23. 3. Review of resident 3's care record revealed: *On 11/27/23 at 2:15 p.m. the resident had returned to the facility after a three-night hospital stay related to a urinary tract infection. *There was no documentation in the care record indicating the resident had a change of condition before the hospital stay, what day she had gone to the hospital, or how she was transported to the hospital. 4. Interview on 3/4/24 at 10:15 a.m. with executive director (ED) A regarding the schedule for licensed nurses revealed: *There was a licensed nurse scheduled Monday thru Friday from 8:00 a.m. to 5:00 p.m. *CSD B was on call Monday thru Friday from 5:00 p.m. to 7:00 p.m. *They used an on-call nurse service called Aspire: -Monday thru Friday from 7:00 p.m. to 7:00 a.m. -Saturday and Sunday twenty-four hours a day. -The hours would change if a holiday fell on a weekday. Observation and interview on 3/4/24 at 2:15 p.m. with UAP C revealed: *When there was not a nurse in the facility, they would contact the nurse on-call when a resident fell or had a change of condition. *The nurse on-call would then have given them instructions on how to care for the resident over the phone. *UAPs could document the vital signs they took in the residents' care record. *If a resident had a fall the UAPs were responsible for filling out an incident report but	S 337		

Jennifer Weyrich Executive Director 3-22-2024

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S 337	Continued From page 3 not writing a note in the resident's care record. *She was able to open an electronic care record, show how to document vital signs, and fill out an incident report. Interview on 3/4/24 at 2:25 p.m. with UAP D revealed: *If a resident had a fall, he would notify a nurse and get instructions on how to care for the resident. *He would fill out an incident report. *If he was instructed by the nurse to obtain more vitals signs after the fall he would write the vitals signs on a piece of paper, but would not document the vital signs in the medical record. Interview on 3/4/24 at 2:45 p.m. with ED A and CSD B revealed: *When the UAPs were given direction by a nurse they were good about following back up with the nurses. *If a nurse instructed the UAP to obtain vital signs they expected the UAP to always document those vital signs in the resident's care record. *They agreed the nurse had given specific instructions on how to perform vital signs after resident 1's fall on 1/15/24 and the vital signs had not been documented in the care record. *CSD B indicated she would have expected the nurse who answered the call regarding resident 1's low heart rate and blood pressure to have instructed the UAP to call an ambulance and have the resident transported to the hospital. *Resident 2 did fall twice on 10/26/23 at 12:15 p.m. and at 9:20 p.m. -They agreed both falls had not been documented in resident 2's care record. *The nurse was responsible for documenting in the resident's care record after a resident had a fall.	S 337		

Jennifer Weyrich Executive Director 3-22-2024

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S 337	Continued From page 4 *The nurse was responsible for documenting when a resident had a change of condition, went to an appointment, or was admitted to the hospital. *They both agreed there was no documentation present in resident 3's care record to indicate the reason or when she was admitted to the hospital. 5. Review of the provider's November 2014 Documentation policy revealed: *"The Community maintains a complete, ongoing, and organized resident record on each resident from the time of admission until termination of the resident's stay at the Community." *"The purpose of the resident record is to provide a view of the resident's identifying information, health history, and status and to provide communication among practitioners." *"The resident record complies with federal law, state law, and professional standard of practice and Community policy."	S 337		

Jennifer Weyrich Executive Director 3-22-2024

South Dakota Department of Health

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{S 000}	Compliance Statement A revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 5/15/24 for deficiencies cited on 3/4/24. All deficiencies have been corrected, and no new noncompliance was found. Edgewood Pierre LLC is in compliance with all regulations surveyed.	{S 000}		

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