STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435097	A. BUILDING _____ B. WING _____	C 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST LAKE ANDES, SD 57356

(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 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/15/24 through 10/16/24. Area surveyed included resident elopement. Lake Andes Senior Living was found not in compliance with the following requirement: F689.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on review of the provider's South Dakota Department of Health (SD DOH) facility reported incident (FRI), interviews, observation, and record review, the provider failed to keep one of one resident (1) safe from elopement. Findings include: 1. Review of the provider's SD DOH FRI revealed: *On 10/1/24 at 7:02 p.m., Resident 1 walked to the front door of the facility, pushed on the door, and exited the facility without supervision. *He was wearing a Wanderguard (a wearable device that alarms when individual is within proximity of an alarmed door and/or crosses the threshold of alarmed door). -The Wanderguard functioned appropriately and	F 689	F 689 1. In continuing compliance with F689, Accidents/Hazards/Supervision, Lake Andes Senior Living corrected the deficiency for R1 and all like residents by reviewing and revising the Missing Resident/Elopement Process Guideline on 10/29/2024. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 11/06/2024 or prior to the start of their next shift on the revised Missing Resident/Elopement Process Guideline, what constitutes an elopement, and their roles and responsibilities for individuals at risk for elopement by the DON. The facility conducted elopement drills for all shifts on 11/06/2024. All resident wanderguard bracelets were audited and are in working order. All facility door alarms were audited and are fully functional with a backup door alarm in place. The DON and/or designee will audit MARS/TARS for completion of shiftly checks of resident wanderguard bracelet placement and functionality weekly for 12 weeks and then randomly to ensure continued compliance. The maintenance director and/or designee will audit the doors and alarms weekly and document in TELS. The ED and/or designee will audit completion of elopement drills monthly for	11/12/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Clay Brouwer	Executive Director	11/12/2024

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.

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F 689	Continued From page 1 alarmed when the resident exited the building. *At the time the resident exited the building, all staff were assisting other residents. *CNA G spotted resident 1 across the street at a neighboring house. *CNA G brought the resident back to the facility at 7:07 p.m. *Resident 1 was assessed by licensed practical nurse (LPN) D, the resident was not injured, and his vital signs were within normal limits. *Resident 1's daughter was notified, as well as his primary care provider. *The facility initiated 15-minute checks for the following 72 hours. 2. Interview on 10/15/24 at 3:05 p.m. with CNA E and CNA F revealed: *They stated that resident 1 would try to exit the building frequently. *They stated he had gotten physically aggressive with staff at times when they tried to redirect him. *They stated that to verify the resident's Wanderguard was working correctly, they would walk the resident near the exit, and would hear the alarm if it was working. -They said if the resident got outside, there was a different alarm to alert staff the resident had exited the building. 3. Interview and observation on 10/15/24 at 3:30 p.m. with administrator A revealed: *Resident 1 was known for his exit seeking behaviors. *He demonstrated to the surveyor how the front door was locked until the numerical code was entered to exit. *He stated that door would alarm when a resident wearing a Wanderguard was near it. *He demonstrated that by pressing on the door	F 689	F 689 3 months and then randomly to ensure continued compliance. 3. As part of Lake Andes' ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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F 689	Continued From page 2 for 15 seconds which unlocked the door, as a fire safety feature. 4. Interview on 10/16/24 at 8:36 with regional nurse consultant B revealed: *Her definition of an elopement is "A resident getting out of the building without staff knowing." *She stated that resident 1's incident "Was not really an elopement because the alarm went off and he was retrieved immediately." *She stated that elopement drills were conducted quarterly by the facility but was unable to provide documentation of the drills. 5. Interview on 10/16/24 at 8:40 a.m. with director of nursing (DON) C revealed: *She confirmed that resident 1 exited the front door unaccompanied on 10/1/24. *She stated the resident headed west and was found in a neighboring yard on the other side of the road by CNA G. 6. Interview on 10/16/24 at 11:00 a.m. with LPN D revealed: *She recalled on the evening of the incident, she was "doing med pass on the east wing" when resident 1 exited the building. *She stated that resident 1 had exited the building one time before and was found on the ground outside. *She stated that on the night of that incident, she was in another resident's room and was unable to hear the alarm while inside the room. *When asked if there was adequate staffing on night shifts, she replied "it would be nice to have a second 6-10 p.m. CNA." *When asked if resident 1's elopement may have been prevented if there was additional staff, she replied "Yes."	F 689		

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F 689	Continued From page 3 *When asked if the facility performed missing person drills, she replied that she remembered doing one a long time ago. *She confirmed the resident did leave the premises and was found in a neighboring yard on the other side of the street. -She confirmed that the missing person drills were not conducted regularly on the night shift. 7. Review of resident 1's electronic medical record (EMR) revealed: *His care plan identified him as being at risk for elopement. *His progress notes revealed he attempted to exit the facility frequently. -Several progress notes related to his exit seeking and wandering were documented on 8/8/24, 8/16/24, 8/31/24, 9/23/24, 9/24/24, 10/1/24. *Orders in the resident's medical record directed staff to check the Wanderguard function twice daily. -All checks were documented that the Wanderguard was functioning correctly. -On 9/23/24 and 9/24/24, progress notes indicated resident 1 was able to exit through the front door and the Wanderguard did not alarm.	F 689		