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 _____	C 12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR FLANDREAU, SD 57028

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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 12/30/24 through 12/31/24. The areas surveyed were resident safety related to smoking and resident elopement. Flandreau Santee Sioux Tribe Care Center 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: A. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, observation, record review, and policy review the provider failed to effectively implement and follow their policy for 5 of 8 sampled residents (1, 2, 4, 5, and 6) who smoked and accurately assess 1 of 1 sampled resident (3) who vaped. Findings include: 1. Review of the provider's SD DOH FRI regarding resident 1 revealed: *On 11/25/24 during her weekly skin check she was observed to have "what appeared to be a cigarette burn on her abdomen." -That wound measured 0.6 centimeters (cm) x 1cm x 0.1cm.	F 689	IDT reviewed and revised the smoking policy on 1/6/25 to include vaping. Residents 2, 3, 4, 5, and 6 had updated smoking safety assessments completed on 12/31/24 by DON. Residents 1, 3, 4, 5, and 6's smoking care plans were reviewed and revised on 1/22/25 by DON. Resident 2's smoking care plan was initiated on 1/2/25 by MDS Coordinator. All residents have the potential to be affected. All smoking residents care plans were audited for appropriateness by 1/22/25 by DON. On 1/13/25 the IDT updated the Admissions Checklist to include quarterly scheduling of smoking safety assessment. On 1/13/25 the IDT reviewed the Quarterly Checklist expectations. All nursing staff will be educated on the facility's updated resident tobacco use policy, admission checklist, and quarterly checklist by 1/29/25. Staff not in attedance will be educated prior to next shift.	1/29/25 KD 125

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kassie Doty — TITLE: LNHA — (X6) DATE: 1/28/25

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 -A physician's order was obtained to "apply bacitracin to wound once daily and cover with a band-aid. Change daily. Leave uncovered during bath/shower. *Resident 1 had reported she had been out to smoke and the wind caught her smoking apron and hit her cigarette causing the cherry (burning end) to fall off and burn her skin. 2. Interview on 12/30/24 at 2:20 p.m. with resident 1 revealed: *She had received a small burn from her cigarette about a month ago. -She recalled she wore an apron that day because the wind blew it up and hit her cigarette and "knocked the tip off." -The hot end had fallen inside of her shirt. -She confirmed that the burn was on her "belly" and that she did not tell anyone about it "because it wasn't a big deal." *A staff member was always outside with her when she smoked. *She confirmed that the staff had asked her to wear an apron and she had, at times, chosen not to wear it. 3. Observation and interview on 12/30/24 at 2:58 p.m. with resident 1 and registered nurse (RN) E revealed: *RN E was aware that resident 1 had received a burn to her abdomen while smoking that had healed. *The area appeared slightly pink, raised, about the size of the head of an eraser. *RN E stated that residents were supervised while smoking, although some staff supervised by observing the residents through the glass door and windows.	F 689	All staff will be educated on directed in-service topics by 1/29/25. Staff not in attendance will be educated prior to their next shift. The DON or designee will audit all admission and quarterly smoking assessments and care plans according to the MDS schedule x3 months. IDT will audit 1 smoking time daily for 2 weeks, 2 per week for 2 weeks, 1 per week for 4 weeks. All audits will be brought to the facility's QAPI team to review and advise. Addendum: All nursing staff will be educated by the DON on the facility's updated resident tobacco use policy, admission checklist, and quarterly checklist by 1/29/25. Staff not in attendance will be educated prior to next shit.	KD 1/28/25

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F 689	Continued From page 2 4. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on 9/24/24. *Her diagnosis included cerebral infarction, fracture of the left tibia, Type 2 Diabetes, acquired absence of right leg above the knee, "nicotine dependence, cigarettes." *Her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. *Her care plan indicated "The resident is a smoker." -Goals included, "The resident will not suffer injury from unsafe smoking practices ..." and "Resident will Adhere to the Substance Use Policies of the Facility ..." -Interventions included: --"Instruct resident about the facility policy on smoking: locations, times, safety concerns." --"Notify charge nurse immediately if it is suspected resident has violated facility smoking policy." --"Observe clothing and skin for signs of cigarette burns." --"The resident requires a smoking apron while smoking." --"The resident requires SUPERVISION while smoking." *An 11/25/24 Smoking Safety Screen indicated: -"Resident refused smoking apron and burned herself." -The resident's need for adaptive equipment indicated, "Smoking apron" and "Supervision." -"Team Decision" indicated "Safe to smoke without supervision." -"Education [was] done with [the] resident to be safe during smoking and to always wear a smoking apron." *There was no indication in her EMR that a	F 689		

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F 689	Continued From page 3	F 689		

smoking safety screen had been completed on her 9/24/24 admission to the facility.
*An 11/25/24 progress note (PN) indicated, "Skin assessment done this morning after shower. New wound noted on R [right] side of upper abdomen. Approximately .75 cm circular burn. Resident states "it happened a couple [of] days ago." Resident denies telling staff about it when it happened and had refused her smoking apron prior to the incident."
*An 11/25/24 physician's order indicated, "Apply bacitracin to wound once daily and cover with a band-aid. Change daily. Leave uncovered during bath/shower."
*A 12/1/24 PN indicated, "Noted that band aid on mid chest. Res [resident] states has been there since the 25th from a burn which occurred while on a smoking break with her apron on but it was windy and res. went to grab the apron as it flew off and a cherry from the cigarette landed on her chest. She tried to get it off immediately but ended up with a burn. Will monitor and obtain Dr. order for a dressing if needed. cleansed with soap and water and OTA [open to air] at this time ..."

5. Observation and interview on 12/30/24 at 2:30 p.m. of the smoking area with director of social services (DSS) C revealed:
*There were separate smoking times for each neighborhood because of the number of residents who smoked.
*A key fob and a code were required to open the door to the designated smoking area.
*Staff supervised residents when they smoked.
*The residents were not provided with the door code.
*The outside designated smoking area had a red metal-covered pail and a sign that indicated no

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F 689	Continued From page 4	F 689		

smoking beyond that point.
-There was a fenced-in courtyard with walking paths beyond that sign.

6. Observation on 12/30/24 at 3:37 p.m. with RN D of the smoking area revealed:
*RN D assisted the residents by opening the door and supervised the residents while they smoked.
*Resident 3 was in a power chair and had used a vape.
*Resident 4 was in a power chair, did not wear a smoking apron, and did not stay within the designated smoking area while smoking.
*Resident 6 walked independently, wore a smoking apron, and walked beyond the smoking area while smoking.

7. Interview on 12/31/24 at 10:28 a.m. with certified nursing assistant CNA G revealed:
*Residents had four smoking times each day.
*He supervised residents when they smoked.
*Residents were required to wear aprons when they smoked.
-He stated, "No apron, No smoke."
-Some residents refused to fasten the Velcro straps on the apron so he tucked the apron into the side of the wheelchair.
*The smoking area was not covered.
-He would supervise from "inside the doors when the weather was bad."
-At times, he would take residents to smoke in the covered area at the front of the building.

8. Interview on 12/31/24 at 10:40 p.m. with ADM A revealed:
*There was no vaping policy.
-They had referred to the smoking policy.
-She confirmed the provider's smoking policy did not include vapes.

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F 689	Continued From page 5 *She expected residents to stay in the designated smoking area. -If residents went beyond the designated smoking area, she expected staff to report that violation of the smoking policy to the charge nurse. -The front of the building was not a designated smoking area. 9. Review of resident 2's EMR revealed: *He was admitted on 8/20/24. *His diagnosis included "unspecified dementia, moderate with agitation," Wernicke's Encephalopathy, and "nicotine dependence, cigarettes." *There was no indication that a smoking safety screen had been completed since his admission. *His care plan did not include that he smoked or what interventions were required to ensure his safety while smoking. Review of resident 3's EMR revealed: *He was admitted on 10/17/23. *His diagnosis included quadriplegia C5-C7 incomplete, and acute and chronic respiratory failure with hypoxia. *A 10/25/23 "SMOKING- SAFETY SCREEN" indicated: -The resident's need for adaptive equipment indicated "Supervision." -"Team Decision" indicated "Safe to smoke with supervision." -"Vape pen, resident able to operate independently." *There was no indication that an annual or quarterly smoking safety screen had been completed since his admission. *His care plan indicated: -"Resident uses vape products." -"Resident will maintain safe vape practices under	F 689		

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F 689	Continued From page 6	F 689		

the supervision of staff ..."
-"Notify charge nurse immediately if it is suspected resident has violated facility smoking/vaping policy and substance abuse policy."

Review of resident 4's EMR revealed:
*She was admitted on 8/22/24.
*Her diagnosis included paraplegia, depression, anxiety, and "nicotine dependence, cigarettes."
*An 8/22/24 "SMOKING- SAFETY SCREEN" indicated:
-The resident's need for adaptive equipment indicated "Smoking apron."
-"Team Decision" indicated "Safe to smoke without supervision."
*There was no indication that a quarterly smoking safety screen had been completed since her admission.
*Her care plan indicated "The resident is a smoker."
-Goals included, "The resident will not suffer injury from unsafe smoking practices ..."
-Interventions included:
--"Instruct resident about the facility policy on smoking: locations, times, safety concerns."
--"Notify charge nurse immediately if it is suspected resident has violated facility smoking policy or substance abuse policy."
--"Observe clothing and skin for signs of cigarette burns."
--"The resident requires a smoking apron while smoking cigarettes."
*The care plan did not indicate what level of supervision was required while smoking.

Review of resident 5's EMR revealed:
*She was admitted on 2/10/23.
*Her diagnosis included unspecified dementia,

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F 689	Continued From page 7	F 689		

unspecified severity with psychotic disturbance, and "nicotine dependence, cigarettes."
*A 2/22/24 "SMOKING- SAFETY SCREEN" indicated:
-The resident's need for adaptive equipment indicated "Smoking apron," and "Supervision."
-"Team Decision" indicated "Safe to smoke with supervision."
*Her care plan indicated "Resident is a smoker."
-Interventions included "Assess for safety with smoking quarterly and as needed."
*There was no indication that a quarterly smoking safety screen had been completed since 2/22/24.

Review of resident 6's EMR revealed:
*He was admitted on 9/9/24.
*His diagnosis included vascular dementia, mild, with agitation, and "nicotine dependence, cigarettes."
*His care plan indicated he was "a smoker."
*There was no indication that a smoking safety screen had been completed since his admission.

10. Interview on 12/31/24 at 8:31 a.m. with director of nursing (DON) B revealed that she expected the charge nurse or DSS C would have completed smoking assessments when a resident was admitted, quarterly, or when there was a significant change.

11. Interview and documentation review on 12/31/24 at 9:50 a.m. with ADM A revealed:
*She expected smoking assessments to be completed for residents who chose to smoke on admission and quarterly after that policy was revised in November 2024.
-The previous policy stated smoking assessments were completed on admission and annually.

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F 689	Continued From page 8 *She provided resident documentation for review. *She expected that resident 1 would have had a smoking assessment completed when she was admitted on 9/24/24. -That had not been completed. *She expected resident 2 would have had a smoking assessment completed when he was admitted on 8/11/24 and that his care plan would have been updated. -There was no documentation that a smoking safety screen had been completed and the care plan did not contain a focus area on smoking. *She confirmed resident 3 vaped and the last smoking safety screen was completed on 10/25/23 when he was admitted. -She expected an annual smoking safety screen would have been completed in October 2024. --That had not been completed. *She confirmed that resident 4 had a smoking safety screen completed on admission. -She expected a quarterly safety screen would have been completed in December 2024 after the policy changed. --That had not been completed. *She expected resident 5 would have quarterly smoking safety screens completed because that was indicated on her care plan. -Resident 5 had smoking safety screens completed on 2/20/23 and 2/24/24. -Those had not been completed quarterly. *She expected resident 6 would have a smoking assessment completed when he was admitted on 9/09/24 and again quarterly in December 2024. -Those had not been completed. *A "Temporary Smoking Policy Additions" was added to the smoking policy on 11/27/24 to address inclement weather. Review of the provider's revised 11/6/24 Resident	F 689		

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F 689	Continued From page 9 Smoking Policy revealed: *"Smoking is defined as the use of tobacco products in the form of cigarettes, electronic cigarettes, pipes, or other methods of smoking tobacco." *"Smoking is only permitted in the designated resident smoking area, located outside in the memory care courtyard, outside memory care doors." *"The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker the evaluation will include: -Current level of tobacco consumption; -Method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe etc.); -Desire to quit smoking, if a current smoker." *"A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive), by show of noncompliance with facility smoking policy, and is determined by the staff." *" Any smoking related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues." *"All residents with smoking privileges require monitoring/direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. Residents must remain with in 25 ft [feet] of a fire extinguisher, which is located inside the smoke break doors." Review of the provider's 11/27/24 Temporary Smoking Policy Additions revealed: *"Facility supervised smoking times are subject to be canceled due to the inclement weather conditions including but not limited to extreme	F 689		

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F 689	Continued From page 10 temperatures and high winds. The charge nurse on duty will be responsible for determining if weather is deemed safe for resident smoking. This is a temporary safety procedure the facility is required to immediately implement. In the meantime, the interdisciplinary team in consultation with the SD Department of Health and facility Ombudsman will work to determine long term facility policy changes." B. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, observation, and record review, the provider failed to ensure the safety of a resident by not providing adequate monitoring and supervision of a resident identified at a high risk for and with a known history of elopement (leaving the facility without staff knowledge) for one of one sampled resident (6) who was observed by staff (H) to have gone on an unsupervised walk outside and then left the property without staff knowledge of his location for over an hour. Findings include: 1. Review of the provider's 12/30/24 SD DOH FRI regarding resident 6 revealed: *On 12/30/24 at approximately 10:35 a.m. resident 6 exited the facility through the front doors "to walk the emergency access road that circles around [the] facility." *At 10:52 a.m. receptionist H: -Requested maintenance look outside the building for resident 6. -Notified administrator (ADM) A and director of social services (DSS) C that resident 6 had not returned from his walk. -It had been 17 minutes since resident 6 had exited the building for his walk.	F 689	Resident's care plan was updated to include need for staff supervision to exit facility on 12/30/24 LNHA. Resident's activity program was revised to include weekly 1:1 community outing events to community center for exercise, community center for cultural program, or to the library on 1/6/25 bt LSW and Activity Director. Resident's restorative program was reviewed and revised to include daily courtyard walks exercise time to be observed by the restorative aide pending weather on 1/6/25 by MDS Coordinator. LSW reviewed and updated care plans to include staff supervision needs for residents with wanderguards om 1/22/25. DON audited on residents for completed wander/elopement risk assessments on 1/24/25. All residents have the potential to be affecteded. On 1/21/25 the IDT reviewed and revised the Independent Exiting policy and the Elopements and Wandering Residents policy.	

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F 689	Continued From page 11 *At 11:04 a.m. unable to locate resident 6, ADM A alerted the police department, and a community search was initiated. *At approximately 12:07 p.m. resident 6 returned to the facility with a friend who indicated that resident 6 had "walked over to his apartment located behind the facility and they had hung out for a bit." *It had been 1 hour and 32 minutes since he had left the facility. *"Skin check completed resident is uninjured. Resident POA [Power of Attorney] notified. Physician notified." 2. Interview on 12/30/24 at 3:58 p.m. with ADM A revealed: *The front sliding glass doors have an alarm that will sound but they open automatically. *Resident 6 had been allowed to walk the circle road outside the fenced area around the facility without someone with him. -That was a "non-pharmacological" (without medication) intervention to help with some of his behaviors. *Receptionist H was allowed to let resident 6 leave the building when he requested to walk the circle. -She expected receptionist H to alert additional staff if resident 6 did not return within 10 to 15 minutes. *Resident 6 had left the circle and walked to an apartment next door to visit a friend. -They had not been aware that he had a friend who lived at that apartment building. *Resident 6 had been provided a wanderguard after the incident on 10/9/24 to alert staff if he exited the building when there was no staff at the front reception area to turn off the alarm or if he attempted to exit the building in the evening, or	F 689	On 1/29/25 all staff will be educated on policy revisions and expectations as well as additional directed in-services topics. Staff not in attendance will be educated prior to their next shift. The DON or designee will audit all admission and quarterly assessments for wandering risk according to the MDS schedule for x3 months. DON or designee will audit wanderguard wearing residents care plans 1 time per month for 3 months. LSW will conduct weekly check-ins with resident 6 to assess and address moods, behaviors, and intervention effectiveness for 6 weeks. LSW and DON will bring results to QAPI to determine effectiveness of interventions and needs for intervention adjustments as well as audit results. Addendum: On 1/29/25 all staff will be educated on policy revisions and expectations as well as additional directed in-services topics by LSW and LNHA. Staff not in attendance will be educated prior to their next shift. DON or designee will audit all wanderguard care plans 1 time per month for 3 months or more often as their behavior monitoring indicates.	KD 1/28/25

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	43A139	A. BUILDING _____ B. WING _____	C 12/31/2024

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without staff knowledge.
*Resident 6 was allowed to leave the facility with a responsible party.
-She expected him to be "signed out" when he left.
*An elopement was reported to SD DOH a couple of months ago when resident 6 exited the building without a responsible party.
*She did not consider resident 6 having been outside the facility on a walk that day an "elopement."
*She considered him leaving the property without a responsible party signing him an elopement.

3. A review of the provider's 10/9/24 SD DOH FRI regarding resident 6 revealed:
*Resident 6 told the dietician that he was meeting his sister-in-law, and they were going to Sioux City for the night then exited the building.
*Resident 6 was educated on the need to wait for his sister-in-law to come into the building and not wait outside.
*Interventions put in place include:
-Resident 6 was placed on 15-minute checks for 24 hours.
-A whiteboard was put in resident 6's room to orientate him to the current date, upcoming events, and special instructions
-The provider's Elopement and Wandering Residents policy was reviewed.
-Resident 6's care plan was updated on 10/11/24 to reflect additional preventions and non-pharmacological interventions.
-*An elopement drill was conducted with staff on 10/10/24.

4. Observations on 12/30/24 between 12:15 p.m. and 4:30 p.m. of the exterior of the facility and surrounding area revealed:

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*It was lightly raining, and it was 36 degrees.
-There was no snow on the ground.
*There was a circular driveway around the entire building.
-That was an extension of the parking lot that went towards the back of the facility beyond the fenced-in areas.
*There was an apartment building to the right of the facility approximately 500 feet from the facility according to a map.

5. Interview on 12/31/24 at 11:00 a.m. with receptionist H revealed:
*She had turned off the alarm and allowed resident 6 outside to go for a walk yesterday (12/30/24).
-She notified maintenance and ADM A when resident 6 had not returned after 15 minutes.
*Resident 6 had been allowed to go for walks around the building alone, but now he needed to have someone with him.

6. Interview on 12/31/24 at 11:20 a.m. with resident 6 revealed he:
*Enjoyed walking outside and knew he was not allowed to leave without notifying staff.
*Had recently learned that his "ex-brother-in-law" lived next door.
-His ex-brother-in-law had visited him at the facility and told him where he lived.
*Had walked to that apartment yesterday (12/30/24) and had not told staff.
-He said he asked his ex-brother-in-law to sign him out and his ex-brother-in-law had reassured him it was "fine."

7. Review of resident 6's EMR revealed:
*He was admitted on 9/9/24.
*He was 55 years old.

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*His diagnosis included vascular dementia, mild, with agitation, other stimulant abuse, wandering in diseases classified elsewhere, Diabetes Mellitus, and nicotine dependence.
*His Brief Interview for Mental Status (BIMS) assessment score was 9, which indicated he was moderately cognitively impaired.
*A 12/10/24 Wandering Risk Scale indicated he was able to walk, had a history of wandering, and had a high to wander.
Review of resident 6's care plan revealed:
*"Resident is independent with ambulation. [Resident 6] likes to walk the halls and neighborhoods for exercise."
*A 10/9/24 focus area indicated he had a high risk of wandering and elopement due to mobility and dementia.
-Goals included:
--"Resident will have no elopements during the review period."
--"The resident's safety will be maintained through the review date."
-Interventions included:
--"If available, offer to walk with [the] resident outside the facility loop. May walk [the] loop by self if front staff are available for observation."
--"Attempt to redirect or distract resident by offering to walk with him back to his room/wing for [a] snack, coffee, games, etc."
--"Wanderguard in place on resident's ankle."
--"Nurse to verify if wanderguard is functioning properly once a day."
--"Staff to verify wanderguard is working properly every shift."
--"Whiteboard calendar in [resident 6's] room to help with orientation. Appointments and visitations from friends and family to be noted on [the] calendar. Include time and instructions."
*A 9/22/24 focus area indicated, "The resident

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has impaired cognitive function/dementia or impaired thought process r/t [related to] vascular dementia. Resident short term memory is significantly impaired. Resident often repeats the same story multiple times in short spans of time."
-Interventions included:
--"Cue, reorient and supervise as needed."
--"Resident wears [a] wanderguard on [his] ankle due to history of elopement/getting lost while walking at home."
--"Observe/document/report PRN [as needed] any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status.

8. Interview on 12/31/24 at 11:42 a.m. with director of nursing B regarding resident 6's elopement revealed:
*Resident 6 had a BIMS score of 9, which indicated he had moderate cognitive impairment.
*She had completed a wandering assessment on resident 6.
-The assessment had several questions that determined a number score.
-That number score was coded "High Risk to Wander."
*She had been involved in the decision to allow resident 6 to walk outside around the loop when staff were aware of his location.
*Resident 6 had "episodes of forgetting" but him walking outside had not been an issue before.
*The facility contacted Dakota at Home regarding placement options as they had been aware of the need to balance resident 6's abilities with keeping him safe.
*Resident 6 was to be checked on every 15-minutes.

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F 689	Continued From page 16 -It had not been determined how long those would be needed, possibly "indefinitely". 9. Interview on 12/31/24 at 12:54 p.m. with DSS C revealed: *Resident 6 had been at the facility, was discharged home to reside with his brother, and then returned to the facility in September. -His brother had noticed resident 6 had increased behaviors and he was unable to care for him at home. *Resident 6 returned with increased behaviors that included "outbursts" of swearing and being short-tempered with staff. He was not aggressive. -Walking was an intervention that helped decrease those behaviors. *She initiated a referral with Dakota at Home in October for "options planning," to seek alternative placement if it was needed. *She had completed his last BIMS assessment which indicated a score of 9 (moderately cognitively impaired), -She stated, "Sometimes that score seems accurate, and other times it does not." *She had requested a neuropsychiatric evaluation to determine if resident 6 had an undiagnosed mental health condition. *Resident 6 had recently learned that a friend lived next door. -The staff had not been aware of that. -The friend was not familiar with the facility policies. --Education was provided to the friend and resident 6, that resident 6 needed to be signed out by a responsible party before he could leave the facility. 10. Interview on 12/31/24 at 1:30 p.m. with ADM A regarding resident 6's care plan revealed.	F 689		

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F 689	Continued From page 17 *The person responsible for updating the care plan was unavailable for an interview. *She expected resident 6's care plan to accurately reflect his unique circumstances and specific needs. *She expected the care plan to be updated quarterly and with any changes. -On 12/30/24 she updated resident 6's care plan after the elopement to reflect the need for supervision when he walked outside. Review of the provider's revised 6/2/24 Elopement and Wandering Residents policy revealed: *" This [provider's name] ensures that residents who exhibit wandering behaviors and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk." *"Elopement occurs when a resident leaves the premises or a safe area without authorization ... and/or any necessary supervision to do so." *"The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation, and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary." *"The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan." *"Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be	F 689		

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F 689	Continued From page 18 added to the resident's care plan and communicated to appropriate staff." *"The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff."	F 689		