South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10746	A. BUILDING: _____ B. WING _____	C 05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PRAIRIE CROSSINGS WATERTOWN AL,	420 9TH ST. SE WATERTOWN, SD 57201

(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 5/6/24. The area surveyed was quality of life and freedom from verbal, sexual, physical, and mental abuse. Edgewood Prairie Crossings Watertown AL, LLC was found not in compliance with the following requirement: S838.	S 000	CSD to review the vulnerability section of the assessment for any residents with sexual behaviors and updating the care plan. CSD updated the care plans again on 5/28/24. Regional Nursing Director (RND) completes quarterly audits of five random charts and will continue to do so. ED and CSD will review incidents to ensure the care plans are updated appropriately. ED and CSD will review bi-weekly through July 30, 2024. All memory care residents are vulnerable. All residents are noted to be at risk to be abused on their care plan. Resident #1 care plan has been updated 5/28/24. safety checks have been increased to every 15 minutes as of 5/6/24. Resident #2 care plan has been updated 5/28/24. Safety checks have been increased to every 15 minutes as of 5/6/24. Family approved to try a new medication the Dr. suggested. The first was given 5/17/24. Additional education has been assigned to employees. One of the training video's is from the Dementia Care Partner Talk Show with dementia educator Teepa Snow Ep. 222 Sexuality & Dementia. Another is to review the section from the Clinical Services Manual pages 51-58 on Abuse Prevention, Intervention, Reporting, and Investigation.	6/20/24
S 838	44:70:09:09(4) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: 4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property; 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 ensure one of one sampled resident (1) who was cognitively impaired received adequate care and monitoring that resulted in an incident of resident abuse. Findings include: 1. Review of the 5/1/24 SD DOH FRI revealed: *On 4/28/24 at 11:00 p.m., certified medication aide (CMA) C was performing a 30-minute safety check for resident 2 and discovered he was not in	S 838		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Prokop, Executive Director — TITLE — (X6) DATE: 5/30/2024

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S 838	Continued From page 1 his room. CMA C continued down the hallway and checked all rooms for him. *When she reached resident 1's room, she found her door locked. CMA C unlocked the door and, upon entering the room, found resident 2 standing over resident 1 as she was lying on her bed sleeping. *Resident 1's shirt was pulled up and her breasts were exposed. Resident 2's hand was within resident 1's waist-band of her pants. *CMA C instructed resident 2 to leave resident 1's room and personal care assistant (PCA) D entered the room and escorted resident 2 back to his room. *CMA C attended to resident 1 and, upon leaving her room, locked her door to prevent other residents from entering her room. *The provider had not indicated in the report how they would keep other residents safe from similar incidents. Review of Resident 2's electronic medical record (EMR) revealed: *He was admitted to the facility on 3/26/24. *His diagnoses included: -Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (primary). -Unspecified mood [affective] disorder. -Primary insomnia. *His 3/26/24 admission assessment completed by clinical services director (CSD) B revealed: -He was admitted for help with his activities of daily living and and management of his medications. --He needed some assistance with dressing (zippers, buttons, tying shoelaces, etc.), grooming/hygiene (teeth, dentures, hair), toileting, and bathing/showering.	S 838		

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S 838	Continued From page 2 --He used a wheeled walker for assistance with ambulation. -He needed safety checks every 30 minutes. -He was not at risk of abusing other vulnerable adults. -He exhibited sexually inappropriate behavior with staff while they provided care. -He only needed minimal redirection occasionally. -His Saint Louis University Mental Status (SLUMS) examination was scored at 13 indicating dementia. *His 4/22/24 30 day assessment completed by CSD B revealed: -The only change from his previous assessment was a weight loss of six pounds. -He was not at risk of abusing other vulnerable adults. -He exhibited sexually inappropriate behavior with staff while they provided care. -He only needed minimal redirection occasionally. Review of Resident 2's progress notes revealed: *On 4/5/24 a progress note was entered by CSD B which stated, "Resident is doing well since admit, however he has several sexual behaviors. He will ask staff to touch his private area, and try to touch staff inappropriately. He has been caught rubbing other residents' hands ... Writer has had a talk with resident regarding these behaviors ..." *On 4/9/24 a progress note was entered by CSD B which stated, "Resident received a new order in regards to his sexual behaviors. He will start Olanzapine 2.5mg once daily. Resident's wife was notified of the new medication and is okay with him starting this to see if it helps ..." *On 4/22/24 a 30-day assessment note was entered by CSD B which stated, " Resident has adjusted okay since admission ... His behaviors are sexual in nature. He will make sexual comments to female staff during cares mostly but	S 838		

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S 838	Continued From page 3 may make comments at random times. He will remain on every 30 minute safety checks ..." Review of the provider's 4/28/24 resident-to-resident incident report clinical review for resident 2 revealed: *Resident had sexual behaviors towards staff since his admit. *Resident 2 and resident 1 "go into each others rooms frequently and visit with each other." *No physical harm to either resident. The incident was caught by staff before it escalated. *No mention was made regarding interventions for resident 2. Review on 5/6/24 of resident 2's current Master Care Plan dated 4/22/24 revealed: *The resident remained "not at risk to abuse other vulnerable adults." *His safety checks remained at every 30 minutes. *There were no changes made to his care plan after the 4/28/24 incident. Observation and interview on 5/6/24 at 11:04 a.m. with resident 2 revealed: *He was in the main dining room and walked with a shuffling gait and four-wheeled walker to his room. *He had been living in the facility a few months. *His wife visited him every other day. *He could not remember what medications he took. *When asked about his special interests or hobbies, he replied he used to be a farmer and enjoyed being outside, but "not since I've been here" and stated "I live a boring life." *He had not been sleeping well at night. Sleep had not always been a problem as he worked physically on his farm, but since his admission, it had been hard to get to sleep.	S 838		

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S 838	Continued From page 4 Review of Resident 1's EMR revealed: *She was admitted to the facility on 12/9/23. *Her diagnoses included: -Alzheimer's Disease with Early Onset (primary). -Mild cognitive impairment of uncertain or unknown etiology. -Generalized anxiety disorder. *Her 12/12/23 admission assessment completed by CSD B revealed: -She needed some assistance with putting on and taking off her anti-embolism stockings (TED hose), dressing (zippers, buttons, tying shoelaces, etc.), and bathing/showering. -She needed safety checks every 30 minutes. -She was at risk to be abused (physically, verbally, emotionally, financially, and/or sexually) as she lived in an environment with other confused persons. --Staff were to proactively monitor residents. --Staff were to monitor the activities/behavior of residents at all times and proactively intervene to prevent altercations. -She had sexually inappropriate behavior and often interacted and hugged other men. --She responded to redirection and reminders that other men were not her husband. -She was verbally abusive at times and had used foul language with angry outbursts towards staff. -Her SLUMS examination was scored at 7 indicating dementia. Review of Resident 1's progress notes revealed: *On 3/7/24 a monthly behavior progress note was entered by CSD B which stated, "Resident continues to thrive in memory care. Her behaviors are redirectable. The behaviors consist of agitation when it's time to toilet and when she demands medications, food, or fluids. She may swat staff when she isn't getting what she wants.	S 838		

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S 838	Continued From page 5 She does walk hand in hand with other female residents. She has not had any sexual behaviors in a while ..." *On 4/29/24 an assessment post incident report by CSD B stated, "Writer was notified by staff that another resident was in her room touching her inappropriately. When writer came in on 4/29 Monday morning an assessment was performed. Writer checked over residents body and did not find any bruising or redness of any sort. State report was completed and was accepted. Dakota at Home was notified as well of the incident. Will continue to watch these to residents closely and keep them apart." Review of the provider's 4/28/24 resident-to-resident incident report clinical review for resident 1 revealed: *"No physical injuries, the incident was caught by staff before anything further happened." *"These two residents go into each other's rooms frequently and visit with each other." *"[Resident 1's name] has no recollection of this incident as she was sleeping." *"Staff to increase safety checks for both residents and keep [resident 1's name] door locked at all times to prevent any other incidents." *Both residents remained on 30-minute safety checks after the incident. Review on 5/6/24 of resident 1's current Master Care Plan dated 1/8/24 revealed: *The resident remained " ...at risk to be abused (physically, verbally, emotionally, financially, and/or sexually)." -Her measures to minimize risk remained unchanged. *Her safety checks remained at every 30 minutes. *There were no changes made to her care plan after the 4/28/24 incident.	S 838		

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S 838	Continued From page 6 Interview on 5/6/24 at 11:47 a.m. with resident 1 and her husband revealed: *She was limited in her speech and her husband provided the following information. *She was at another memory care facility and moved to this facility on 12/5/23 as she was bored at the other memory care facility and there were more activities at this facility. *He was aware of incidents with resident 2: -About a month ago around this time of day [resident 2] was in her room. -There was another incident a week and a half ago that occurred at night. *The provider had called regarding the incidents. Interview on 5/6/24 at 12:32 p.m. with CSD B revealed: *She was a registered nurse. *Regarding the 4/28/24 incident she stated: -Resident 2 was fully dressed and resident 1 was sleeping and not aware of what was going on. -Resident 1's shirt was up and her right breast was fully exposed and her left breast was partially exposed. -Resident 2's hand was in her waistband, but "not down far enough to be touching her genitalia." -After PCA D escorted resident 2 out of the room, CMA C woke resident 1 up, took her to the bathroom, and noted she had no indications of distress. -Regarding resident 1: --She had been on hourly checks, and her safety checks were increased to 30-minute checks. --Her room door was to remain locked when she's inside the room during her naps during day and at night. --She was able to lock and unlock her room door. -Regarding resident 2:	S 838		

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S 838	Continued From page 7 -He was on 30-minute safety checks that remained unchanged. -She stated the 30-minute safety check is the most frequent safety check they could do. Review of the provider's March 2024 Abuse Prevention, Intervention, Reporting and Investigation policy revealed: *"Residents are to be free from verbal, sexual, physical, emotional/mental abuse, ..." -"Sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault." -"Sexual abuse can mean penetration, verbal harassment, or physical contact without penetration." *"Remember the Plan of Care may need revisions depending on the nature of the incident."	S 838		

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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 7/12/24 for deficiencies cited on 5/6/24. All deficiencies have been corrected, and no new noncompliance was found. Edgewood Prairie Crossings Watertown AL, LLC is in compliance with all regulations surveyed.	{S 000}		

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