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
	46983	A. BUILDING: ______ B. WING ______	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA SACRED HEART MAJESTIC BLUFFS	2109 W 11TH ST YANKTON, SD 57078

(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 licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 3/5/24 through 3/6/24. Avera Sacred Heart Majestic Bluffs was not in compliance with the following requirements: S165. 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 3/5/24 through 3/6/24. Areas surveyed included physical environment and elopement. Avera Sacred Heart Majestic Bluffs was found not in compliance with the following requirements: S165.	S 000	Facility reviewed the current Elopment & Wandering Process. On 3/7 the alarm system for memory doors were changed to audible alarm. When the code is not entered, the door now audibly alarms and staff must manually reset. the facility license was also corrected to appropriately reflect cognitive services only being offered in the memory area. Missing Resident Policy was reviewed and revised. Occurrence was from 2/25/24 therefore elopement for that time period could not be corrected. Correction was limited to staff education and ongoing alarm monitoring process. Identified resident no longer resides at the facility. All other residents in memory area were also reviewed that they were being followed according to facility process. Inservices on the facility Wander Management Process will be completed for Nurses and Resident Assistants by Nurse Educator by 3/29/2024. Monitoring and Audits of the door alarm process will be done by the facilty nurses weekly x4 weeks, then monthly x3 months, then quarterly x3 quarters. Nurses will report the findings to the Director of Quality/Service Excellence for compiling and submitting to Facility QAPI Committee for review and recommendations monthly x3 months, then quarterly x3 quarters.	3/29/2024
S 165	44:70:02:17 Occupant Protection Each facility must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the physical needs of any resident admitted to the facility. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation, testing, interview, and record review, the provider failed to operate the facility in a manner to avoid injury or danger to any occupant by not responding to the alarm on one randomly observed exit door (Internal memory wing exit near the salon). Findings include:	S 165		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anthony L Erickson
TITLE: Vice President - Senior Services
(X6) DATE: March 25, 2025

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S 165	Continued From page 1 1. Observation and testing beginning on 3/6/24 at 12:10 p.m. revealed the unattended main entrance to the memory wing (exit door near the salon) was equipped with a door alarm. That alarm did not audibly sound, and staff did not come to that door when the alarm was tested by opening that door without bypassing the alarm. Interview with maintenance supervisor H at the time of the observation and testing confirmed those conditions. He stated the alarm was not audible because the alarm was only sent to the staff's "walkie-talkies." He also stated the facility's door alarm system kept a log of when the door alarm was activated and canceled. Record review of the facility's door alarm system log for that door on that same day at 12:28 p.m. revealed the door alarm system was activated when that door was tested at 12:10 p.m. The door alarm system log also revealed that alarm was canceled at 12:14 p.m. Further observation and testing of that door was conducted for a second time at 1:32 p.m. That door was opened, and staff did not respond to any alarm created by opening that door without bypassing the alarm. Further record review of the facility's door alarm log for that door on that same day at 1:42 p.m. revealed the door had alarmed when tested again at 1:32 p.m. and that alarm was canceled again at 1:36 p.m. Further testing on that same day revealed all exterior doors of the building were unalarmed and would allow residents to leave without any notice.	S 165		

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This deficiency had the potentially affect all residents of the memory wing with cognitive impairment.

B. Based on review of the South Dakota Department of Health (SD DOH) event report, observation, record review, interview, and policy review, the provider failed to ensure:
*The safety of one of one sampled memory care area resident (1) who had left the building unsupervised and without staff knowledge.
*They had a policy implemented for the memory care area door alarms and staff responsibilities related to those door alarms to ensure resident safety.
-If or when a resident exited the memory care area six of six exit doors in other areas were not attended, alarmed, or locked to prevent the resident from leaving without staff knowledge.
Findings include:

1. Review of the 2/25/24 SD DOH event report for resident 1 revealed:
*She was admitted to the facility on 8/22/22.
*Her Brief Interview for Mental Status (BIMS) score was a 3, indicating several cognitive impairment.
*She walked independently and liked to spend time outside.
*She had removed the Wanderguard.
*At 3:00p.m. on the above date she was found in front of the building's entrance by resident aide (RA) B who had been working in another unit and brought her back inside.
-The report did not indicate how long she had been outside without staff knowledge or if a door alarm sounded.
*Registered nurse (RN) D was notified of the event and determined additional interventions were needed.

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*Interventions to prevent a future elopement included the use of two Wanderguard devices instead of the one she had previously worn and increased room checks.

Review of resident 1's electronic medical record documentation on 2/25/24 at 4:04 p.m. by resident assistant (RA) B revealed:
*RA B returned with resident 1 to the memory care area.
-She went to find another Wanderguard device due to resident 1's repeated removal.
-She located the staff member assigned to the memory care area, RA A, assisting another resident with a shower.
*When RA B returned to the resident's room she noticed the resident had left the unit again and was found outside near a parked vehicle.
*Two Wanderguard devices were applied and resident 1 was brought out to the gated patio adjacent the memory care area.
*An additional staff member was located to stay with resident 1 while RA A completed the medication pass.

2. Observation and interview with RN D and RN E on 3/5/24 at 9:00 a.m. upon entry through the main entrance to the facility revealed:
*The entrance doors and the door adjacent to the entrance were not locked. The doors did not alarm when opened. There were no employees monitoring the doors.
*RN D and RN E indicated there were no alarms or locks to any of the exit doors to prevent residents from leaving the building without staff knowledge.
*All doors to the outside were able to be opened to get in and out of the building during day hours.
*The doors to the outside did lock at night to prevent people from entering the facility.

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S 165	Continued From page 4 *Residents living in the building could have left the building at any time. *All residents were assessed at least every six months for declining mental cognition. 3. Observation and interview on 3/5/24 at 9:15 a.m. with RN D and RN E regarding the double doors to the memory care area revealed: *There were no locks on the doors. Residents were able to enter or leave the memory care area. *There were alarms on the double doors. *All but three residents living in the memory care area had Wanderguard devices. *When anyone wearing a Wanderguard device attempted to leave the memory care area a loud alarm sounded. -Staff would then have to go to the Wanderguard keypad to reset the alarm. *There were small black push buttons on the inside and outside of the memory care entrance. -The buttons were raised approximately five feet and hidden on the inside of the memory care area. -They were called silent alarms. -If someone attempted to enter or leave through those doors a voice would have sounded for any staff members that had walkie talkies to alert the staff that someone was coming or going from the memory care area. -There was a walkie talkie placed in the living room of the memory care area that went off and could have been heard in the kitchen, dining room, living room and quietly in the hallway. -RN D and RN E stated the staff encouraged visitors to push the black buttons when they came into or left the memory care area so that the staff did not have to come to the door and reset the silent alarm. -If the Wanderguard device failed to work or if the	S 165		

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resident removed the Wanderguard device, the staff would have to rely on the silent alarm.

4. Review of resident 1's Wanderguard Check flowsheets from 1/1/24 through 3/4/24 revealed:
*The memory care area staff documented the checks twice daily.
*Most of the checks occurred at the breakfast hour and before bedtime.
*The staff documented if the Wanderguard device was in place and attached to resident 1, and if the device was working properly.
*59 of the 132 checks were documented that the Wanderguard device was not in place, or was not working properly, or was left blank.

5. Observation on 3/6/24 at 9:15 a.m. of the exit doors outside of the memory care area in the assisted living halls revealed six of six exit doors were not attended, alarmed, or locked. Those doors were in the following areas:
*The entrance door.
*The single door beside the entrance door.
*The door in the hall outside the kitchen that led to the memory care area back exit.
*The craft room with an exit through the outside deck with steps to the ground.
*The first-floor patio door.
*The exit door at the end of the 100/200 hall that led to the garage.

6. Interview on 3/6/24 at 9:30 a.m. with director of nursing (DON) F and RN E regarding the use of walkie-talkies and staffing revealed:
*There were three staff members at all times. There was one staff member upstairs, one in the memory care area, and a third staff would float where help was needed.
*All nurses and care staff carried a walkie-talkie.
*The silent alarm in the memory care area went

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off all the time.
*All staff members were aware of the silent alarm and could have gone to investigate if the alarm was not reset.
*"The silent alarm was not a primary alarm, it was a secondary alarm."
*They confirmed their current alarm system was not effective in preventing resident 1 from leaving the memory care area and the building without staff knowledge.

Resident 1 was discharged from the memory care area on 3/5/24 to a long-term facility closer to her family.

7. Review of the provider's August 2022 Missing Resident procedure revealed:
*Area missing resident, the team leader would make an announcement over the walkie talkies for everyone to stop and look for this identified missing resident and be sure to do a quick look on their area where the resident was last seen. All rooms would be searched.
*The team leader would review the security camera.
*If the resident was not found after the first search the team leader would have to use a phone to notify everyone.
*Staff would stay in their areas.
The policy had not addressed door alarms or Wanderguard devices.

When DON F was asked for policies on 3/6/24 at 2:30 p.m. for:
*Utilizing float RA's in emergencies/elopements or communication during emergencies.
*The use of the Wanderguard alarm and the silent alarm.
*The security of the exit doors, door alarms, or attending the doors.

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S 165	Continued From page 7 There were no policies.	S 165		

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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 4/4/24 for deficiencies cited on 3/6/24. All deficiencies have been corrected, and no new noncompliance was found. Avera Sacred Heart Majestic Bluffs is in compliance with all regulations surveyed.	{S 000}		

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