STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 on 11/26/24. The area surveyed was resident elopement. Dells Nursing and Rehab Center Inc was found to have past non-compliance at F689 for not ensuring the safety of a resident with cognitive impairment who left the facility without staff knowledge.	F 000		
F 689 SS=D	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 South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, and record review the provider failed to ensure the safety of one of one sampled resident (1) identified at risk for elopement, who had eloped (left the facility without staff knowledge) after staff turned a door alarm off. Failure of staff to ensure the door alarm was reactivated resulted in the resident's elopement and put her at risk for physical injury or serious harm. This citation is considered past non-compliance based on the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 11/20/24 SD DOH FRI	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carolyn Thiel | TITLE: Administrator | (X6) DATE: 12/4/24

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 revealed: *On 11/20/24 at 1:00 p.m. certified nursing assistant (CNA) G reported to licensed practical nurse (LPN) H the fire exit door in the living room was cracked open. *The alarm did not sound. *Resident 1 was standing on the sidewalk by the door. -She was last seen prior to that eating lunch in the dining room. -She stated she was going to get hot chocolate. *Resident 1 was immediately put on one-to-one observation with activities assistant F. *Her vital signs were taken and were within normal limits. *No injuries were noted at the time of the incident. *She was wearing a Tile tracking device and a watch with the capability to track her location. *The charge nurse notified administrator A, director of nursing (DON) B, the physician, and resident 1's son of the incident. *The door alarm system was immediately checked, and the alarm for that door was noted to be turned off. *The door alarm was turned back on and noted to be working. Observation on 11/26/24 at 9:30 a.m. at the nurse's station revealed: *The door alarm system was on. *New education for staff was posted directly under the panel. *Observation and interview on 11//26/24 at 10:30 a.m. with resident 1 in her room revealed she was watching TV in her room with her husband and had no concerns at this time. *Interview on 11/26/24 at 10:47 a.m. in the dining	F 689		

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F 689	Continued From page 2 room with activities assistant F regarding the elopement process revealed she: *Would retrieve the resident from outside. *Ensure they were ok, bring them inside, and get them a cup of coffee. *Notify the charge nurse or her supervisor. Interview on 11/26/24 at 10:52 a.m. with housekeeping assistant E regarding elopement revealed: *She would notify her supervisor and help look for the resident. *If she found the resident, she would call 911 so they could do an assessment. *She would notify her supervisor that the resident was found. Interview on 11/26/24 at 11:05 a.m. with CNA D regarding the elopement process revealed she: *Would retrieve the resident if they got outside. *Would make sure they were ok. *Bring them inside and notify the charge nurse so they could do an assessment. Interview on 11/26/24 at 11:39 a.m. with registered nurse (RN) C regarding education provided after the elopement revealed: *Staff were provided education in a binder regarding elopements. *They were required to read and sign before the next shift worked. *The nurses were now documenting door alarm checks completed each shift in the treatment administration record (TAR) and in paper narcotics count book, the alarm checks on each shift. *The nursing staff continued to monitor resident 1 hourly while she had her watch on, and every 30 minutes once it was removed to be charged.	F 689		

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F 689	Continued From page 3 The staff had participated in monthly elopement drills. Interview on 11/26/24 at 1:10 p.m. with administrator A regarding resident 1's elopement revealed: *The door resident 1 exited through did have an alarm on it. *That door was the only one that did not have a key pad to code out on. *She was placed on 15-minute checks immediately after the incident. *They had provided education for staff regarding which doors were appropriate to use to exit the building, as well as monitoring residents who wandered. *She was auditing the door alarms daily for one week, then she planned to complete weekly audits for four weeks. *Maintenance staff used the living room door to complete maintenance tasks outside. *The process for resetting the door alarms was to silence the alarm button, push the reset button, turn off the alarm switch and then turn it back on. *She thought someone missed the last step and did not turn the alarm back on. *She could not determine which staff member shut off the alarm, so education had been provided to all staff members. *She had ordered a new keypad for the fire exit door in the living room so staff would have to enter a code to exit the building along with the door being alarmed. *The keypad was scheduled to arrive on 11/27/24 and maintenance would install it the day it arrived. *Resident 1 wore a watch that was used with a provider-owned cell phone to track her location. *Resident 1 also wore a Tile tracking device that would show her location if she left the property.	F 689		

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F 689	Continued From page 4 *Staff were also educated to do physical checks on resident 1 hourly during the day and every half hour at night. Interview on 11/26/24 at 1:25 p.m. with DON B regarding the interventions put in place after resident 1's elopement revealed: *She was moved to a different table in the dining room for the exit door to not be in her immediate line of sight. *Immediately after the elopement resident 1 was placed on one-to-one observations with the activity assistant and was taken to Bingo for close monitoring. *She was checked for a urinary tract infection (UTI), as they had discovered that had elevated her exit seeking in the past. *The administrator was in the process of obtaining a door alarm bracelet system for her. *A coded pad has been ordered for the fire door that the resident eloped from. *Alarm checks were added to the TAR and the narcotis countc book for the nurses to check and document. *Resident 1's care plan was reviewed, and the table change intervention was added. Review of resident 1's electronic medical record (EMR) revealed: *Her Brief Interview for Mental Status (BIMS) assessment score was 10 which indicated she had moderate cognitive impairment. *She was monitored one-to-one by activities assistant F immediately after the elopement on 11/20/24. *Staff had documented the 15-minute checks in the TAR. *Her care plan was updated to ensure she was seated in the dining room so the living room exit	F 689		

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F 689	Continued From page 5 door was not in her line of sight. The provider implemented changes to ensure the deficient practice does not recur was confirmed after record review revealed the facility had followed their quality assurance process, education was provided to staff regarding the door alarming process and the new interventions that were added to resident 1's care plan, observations and interviews revealed staff understood the education provided and had implemented those interventions, the door alarms were on and monitored, and the process was being audited ongoing to assist in deterring resident elopement. Based on the above information, non-compliance at F689 occurred on 11/20/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 11/26/24, the non-compliance is considered past non-compliance.	F 689		