DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(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 8/27/24 through 8/28/24. Areas surveyed was elopement, and negligence in resident safety. Avantara Redfield was found not in compliance with the following requirements: F689 and past non-compliance at F600.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, policy review, and interview the provider failed to ensure the safety for one of one sampled resident (1) who staff let out of the building in the early morning hours. Resident left the grounds and his wheelchair got stuck on the railroad tracks, and was unable to get himself free. The county sheriff found him and called the provider	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Diane Forgey, Administrator

TITLE

(X6) DATE
9/12/24

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 600	Continued From page 1	F 600		

to let them know that he was gone. This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the incident. Findings include:
1.Review of provider's 8/23/24 SD DOH FRI for resident 1 revealed:
*His Brief Interview for Mental Status (BIMS) score was 9 (meaning moderate cognitive impairment).
*On 8/23/24 at 3:37 a.m. the resident was assisted out the front door by registered nurse (RN) H.
*RN H had not told other staff that he was outside.
*RN H got busy and forgot the resident was outside.
*RN H received a call from the county sheriff at 5:11 a.m. asking if resident 1 was a resident of the facility.
*The resident was observed by the sheriff on the railroad tracks which was approximately three blocks from the building.
*His diagnoses include:
-Cerebral infarction (stroke).
-Arthritis.
-Hemiplegia (paralysis) right side.
-Aphasia (affects communication).
*He was upset and wanted to go outside when he was awakened by staff when they assisted his roommate.
*Administrator A was notified and drove the facility van to collect him.
-They returned to the facility at 5:44 a.m.
-He had been outside alone for over two hours and stuck on the railroad tracks when discovered.
*Full skin assessment and vitals signs were obtained upon return.
*No marks, bruises, or injuries had been noted.

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F 600	Continued From page 2 *The primary care provider was notified. -An order for Wanderguard (wearable alerting device) was given and placed on resident's wheelchair. *The sister was notified of the incident and the interventions that had been put in place for his safety. *Interventions included: -Resident 1 added to elopement binder. -A Wanderguard was placed on his wheelchair. -He was moved to a private room. -He was to be supervised at all times while outside by the care staff. -His care plan was updated with new interventions. -Provider reviewed all the residents with BIMS scores less than 11 for appropriate interventions. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 8/28/24 after record review revealed: *The facility had followed their quality assurance process, and education was provided to all nursing care staff. -The nursing staff had been educated on their abuse and neglect policy. -No resident should have been outside after dark. *New interventions for resident 1 included: -He must be supervised at all times while outside. -A Wanderguard was placed on his wheelchair. *Corrective actions for the nurse had included: -Education on their abuse and neglect policy. -Preventing and responding to abuse. -Preventing, recognizing, and reporting abuse. -Understanding of wandering and elopement. -Review of the RN job description. *Observations and staff interviews revealed the staff understood the education that had been provided and the revised processes.	F 600		

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F 600	Continued From page 3 Based on the above information, non-compliance at F600 occurred on 8/23/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 8/28/24, the non-compliance is considered past non-compliance.	F 600	1. Resident 2's elopement evaluation was completed, and care plan reviewed and updated. Resident continues to wander and will remove wanderguard when in place, so it has been removed and safety checks initiated. Facility is actively seeking an alternate facility with a secured unit for resident placement but have been unsuccessful in finding placement to date. All residents have the potential to be affected. Elopement risk evaluations have been completed/reviewed on all residents and those found to be at risk have interventions in place. 2. The Administrator, DON or designee will provide education and training to all staff about their roles and responsibilities to ensure resident safety and complete documentation. Those not in attendance at the education session will be educated prior to their first shift worked. Additionally, the Administrator, DON, Interdisciplinary Team, and Medical Director will review at the Ad Hoc QAPI meeting to be held on 9/11/24: a. The Elopement Policy and Elopement Binder regarding identifying and care planning for residents at risk for wandering and elopement. b. The logistics for securing all doors as identified in the Wanderguard/Door Signaling Device Policy. c. All residents for their risk of wandering and elopement. d. Which doors residents have successfully exited or linger at. 3. The DON or designee will audit all residents identified who wander or at risk for elopement to ensure interventions are in place and being followed, will interview 5 staff members weekly regarding their knowledge of securing all doors and ensuring resident safety and will audit completion of wanderguard placement/checks and documentation of that weekly x 3 months. Results of audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	
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 South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, observation, interview, and policy review the provider failed to ensure the safety for one of one sampled resident (2) identified at risk for elopement, had eloped (left the facility without staff knowledge) and was outside the building approximately 2 hours and 4 minutes when an activity door was left unalarmed. Failure of staff to ensure the door alarm was rearmed resulted in the resident's elopement and put him at risk for physical injury or serious harm. Specifically, the provider failed to monitor/revise interventions after elopement to ensure resident safety. Findings include: 1. Review of the SD DOH FRI revealed: *On 7/23/24 at 4:41 a.m. resident 2 walked out of	F 689		4. 9/19/24

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F 689	Continued From page 4 facility and the doors alarmed. *Staff assisted resident back inside and put him to bed. *At 4:44 a.m. registered nurse (RN) C deactivated the door alarm and never reactivated it. *Resident C left facility again at 4:59 a.m. *Licensed practical nurse (LPN) E saw resident sitting on the lawn at 6:55 a.m. and staff assisted him inside. 2. Record review of resident 2's orders, care plan, and progress notes revealed: *His physician orders for a Wanderguard included: -On 11/6/23 an order for a Wanderguard to be placed on his right wrist and ankle. -On 6/18/24 a discontinued order for the Wanderguard to his right wrist and ankle. -On 7/23/24 an order for a Wanderguard to be placed on his right wrist. "Check for placement and to see if working correctly every shift. Machine to check working condition is in North med cart." *The resident's care plan included: -"I am elopement risk/wanderer as evidenced by leaving facility unattended, impaired safety awareness. Date Initiated: 03/04/2024." *A progress note on 7/16/24 at 5:45 p.m. stated resident was seen walking out of the facility and staff had assisted him back inside. *A progress note on 8/12/24 at 9:40 p.m. was written by medication aide G about residents Wandergaurd stated, "resident removed????" 3. Observation and interview on 8/27/24 at 11:44 a.m. of resident 2 in his room revealed: *He was laying in bed with only a brief on. *He was not wearing a Wanderguard. *He was pleasant, smiling, and stated he did not	F 689		

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F 689	Continued From page 5 remember anything about his elopement and did not have feelings of wanting to leave. 4. Observation and interview on 8/27/24 at 12:00 p.m. with administrator A about wanderguard placement on resident 2 revealed: *She stated resident 2 should have a Wanderguard on his wrist or ankle. *When asked to verify if a Wanderguard was on, she went to residents' room and confirmed there was no Wandergaurd on the resident. 5. Interview and review of resident 2's electronic medicat record (EMR) on 8/27/24 at 12:05 p.m. with administrator A and director of nursing (DON) B revealed: *They confirmed resident 2's EMR should have a Wanderguard on his right wrist and it should have been checked every shift per physician order. *They were unable to verify when the resident last had a Wanderguard on due to the lack of documentation by the staff. 6. Interview on 8/28/24 at 8:15 a.m. with DON B revealed: *She was not aware that the resident had taken off the Wanderguard before. *The previous Wanderguard was discontinued because they didn't think he needed it anymore based on resident not exit seeking and elopement risk assessements were categorized as "low risk." *The Wanderguards only work on the central door. *The other 11 doors at the facility do not have the Wanderguard alarm system attached to them. *She does not believe having a Wanderguard in place would have prevented the incident because the activity door the resident went out of did not	F 689		

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F 689	Continued From page 6 have the Wanderguard alarm system. *She stated if the staff had reactivated the central alarms, then the elopement could have been prevented. 7. Interview on 8/28/24 at 8:50 a.m. with administrator A revealed: *She confirmed only the central door has the Wanderguard alarm system. *She had spoken to corporate about getting the Wandergaurd alarm system for all the doors. *She would have expected the staff to inform her when a resident was able to take the Wanderguard off because it was an important safety mechanism for residents who elope. 8. Review of providers 11/7/2023 Wanderguards/Door Signaling Devices policy revealed: *"A Wanderguard or other door signaling systems uses a bracelet "token" that will secure the door should a resident who wears such a device come near a door or tries to egress the door." *Procedure: -"6. Placement verification and testing of each Wanderguard or signaling device will be completed daily and recorded on the Mar or TAR." -"7. Maintenance of the door alarm system throughout the facility will be conducted by the Maintenance Department per user manual instructions. Door function will be checked daily."	F 689		