STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49736	A. BUILDING: _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD SPEARFISH SENIOR LIVING LLC	540 FALCON CREST DRIVE SPEARFISH, SD 57783

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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 10/29/24 through 10/30/24. Areas surveyed included elopement, resident abuse, and resident neglect. Edgewood Spearfish Senior Living was found not in compliance with the following requirements: S836 and S838. Findings include:	S 000		
S 836	44:70:09:09(2) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: (2) Maintenance or enhancement of the resident's ability to preserve individuality, exercise self-determination, and control everyday physical needs; This Administrative Rule of South Dakota is not met as evidenced by: Based on closed record review, interview, and the Assisted Living Community Resident Rights handbook review, the provider failed to provide one of one closed record sampled resident's (1) care that contributed to his quality of life in the enhanced care unit (ECU, a secure memory care unit) by failing to ensure appropriate interventions were investigated, implemented, or revised to mitigate his inappropriate behaviors. Findings include: 1. Review of resident 1's closed record revealed:	S 836	In an effort to meet Quality of Life 44:70:09:09(2) an RN will complete a monthly QA for 6 months on residents who have been identified to have behaviors to ensure appropriate interventions have been implemented to assist in mitigating inappropriate behaviors. 12-14-24 RN will review care plans for all MCU residents for accurate non-pharmacological and pharmacological behavior interventions and revise as needed. 12-14-24 All staff will be provided with education by RN regarding the purpose of resident care plans and how they are used in relation to providing resident care. 10% random audit of MCU residents will be completed on a weekly basis for 4 months to ensure behavioral interventions on care plans are accurate and up to date. Audit information will be reviewed on a monthly basis at community Quality Assurance meeting for input and recommendations. 12-14-24 Audit to be performed by RN	

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

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S 836	Continued From page 1 *He was admitted to the ECU on 4/22/24. *His diagnoses included early onset dementia with sundowning (late afternoon and/or early evening occurences of dementia-related behaviors) and aphasia (a language disorder that affects an individual's ability to communicate). -He developed urinary incontinence which was added to his diagnosis list following his admission. *His documented behaviors included agitation, sleeplessness, hallucinations, wandering, aggression towards staff, inappropriate urination, inappropriate interactions with female residents, and refusing staff assistance to complete his activities of daily living specifically medication administration and bathing. *He was discharged from the ECU on 10/21/24 and transferred to an assisted living memory care unit in a nearby community. Review of resident 1's primary care provider (PCP) progress notes (PN) revealed: *PCP F made ongoing changes to the resident's scheduled and PRN (as needed) medications realted to his behavior symptoms. *The following non-pharmacological interventions were also suggested: -"Sleep monitoring." (4/29/24). -"Please 'put to bed.' Tuck pt [resident] in at noc [night]. Leave lamp or closet light on." This plan was discussed with the resident's daughter." (5/6/24). -"Reinforced bedtime routine with staff." (5/14/24). -"Soft measuring tape to measure things." (7/11/24). -A DNA cheek swab. (9/18/24). Review of resident 1's interdisciplinary PNs revealed:	S 836		

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S 836	Continued From page 2 *A care conference note dated 7/22/24 indicated "Resident is experiencing more incontinence" and a later care conference note (9/18/24) had indicated the resident was on a "routine toileting schedule." *A Zoom meeting was held on 9/4/24 and was attended by clinical services director (CSD) B, administrator A, assistant CSD C, Regional Vice President D, and Regional Nurse Director E. -The purpose of that meeting was to discuss how "to retain this gentleman [resident 1] in our community [the ECU]." *It was recommended CSD B was to contact PCP F and request the following: -An order for a DNA cheek swab to determine how resident 1 was metabolizing his behavioral medications. -A consultation with physician/geriatrician G regarding resident 1's behaviors. Interview on 10/29/24 at 3:30 p.m. and again on 10/30/24 at 12:15 p.m. with CSD B regarding resident 1 revealed: *Resident 1's behaviors had increased since his admission and the frequency had peaked around July 2024. *His behaviors had occurred most often at night and sometimes had been related to a poor night-time sleep pattern. *The resident had difficulty making himself understood because of his aphasia and that had seemed to frustrate him. *He had not been referred to a behavioral health specialist. -The behavioral health specialist the facility had used in the past was no longer consulting for the facility's residents. *ECU staffing was based on the ECU census and the acuity of the residents who resided on that unit.	S 836		

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S 836	Continued From page 3 -The ECU was able to accommodate 21 residents. *During the overnight shift (10:00 p.m.-6:00 a.m.) there was one personal care attendant (PCA) assigned to the ECU. -One unlicensed medication aide (UMA) "floated" between the memory care unit on the first floor and on the ECU on second floor. *Between July 2024 and resident 1's discharge on 10/21/24, the ECU staffing pattern had not changed "probably because it couldn't [be]." *Regarding the follow-up CSD B was responsible for completing after the above Zoom meeting on 9/4/24: -The DNA cheek swab was completed but the test results arrived after resident 1 was discharged. -She had not known if PCP F had consulted with physician/geriatrician G regarding resident 1's behaviors. Review of resident 1's behavioral care plan revised on 9/4/24 by CSD B revealed the following: *"Physically abusive/disruptive - Uses violence/destroys property. Does not respond to redirection: - Note: hits staff when resistant to care. *Sexually inappropriate behavior. Does not respond to redirection: - Note: Due to residents dementia, staff redirects resident to his/her room, private area." *Other behavior issues - specify: - Note: res [resident] has been noted to have anxiety/agitation that presents as: fidgeting, pacing, grabbing items from staff/residents, wandering. Staff to provide interventions: 1) provide a calm environment (turn down TV, music, loud noises, lower the lights), assist her	S 836		

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S 836	Continued From page 4 back to her room with her things and what she wants to watch/listen to 2) Distraction/Redirection (take her for a walk, hold her hand, look at pictures in room, redirect the conversation, give her baby or a cat from a life station) 3) offer food/fluids 4) offer toileting (this is a task she at times is fearful/hesitant of), walk with her into the bathroom, hold her hands, may need to hug her while another staff member assists, put a warm wash cloth in her hand while toileting, run water in sink 5) give her items to count 6) staff may call Facility LN [licensed nurse] for further direction." Interview on 10/30/24 at 12:45 p.m. with CSD B regarding resident 1's revised behavioral care plan above revealed: *Staff were expected to refer to that care plan to have known how to manage resident 1's behaviors. *CSD B failed to ensure that his care plan reflected: -The specific cares resident 1 was resistant towards and what strategies staff had been expected to implement to encourage his care participation. -The definition of "sexually inappropriate behavior" and what strategies staff had been expected to implement to mitigate those behaviors from occurring. -The resident had displayed inappropriate urination and whether or not he was on a scheduled toileting program. -Any of the suggested interventions that had been made by PCP F in her PNs referred to above.	S 836		

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S 836	Continued From page 5 -Alternative communication methods that had been tried or used to help the resident make his needs known. *CSD B failed to ensure the staff interventions identified in resident 1's behavioral care plan referred to above had been accurately individualized as follows: -His gender was male not female. -There was no indication of what he enjoyed watching on television or if he had music in his room or what type of music he had listened to. -The resident was able to walk independently and had not needed staff to hold his hand. -Giving him a baby or a stuffed cat had not been interventions used by or appropriate for the resident. -Toileting was not a task the resident was fearful or hesitant of. He had not required staff to hold his hands or a second staff to hug him when he was assisted with toileting. -He was not provided items to count. Review of the October 2019 Assisted Living Community Resident Rights handbook revealed: *Quality of Life - "The ALC (assisted living center) must provide care and an environment that contributes to your quality of life including:" -"2. Maintenance or enhancement of your ability to preserve individuality, exercise self-determination and control every day physical needs."	S 836		
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	S 838		

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S 838	Continued From page 6 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 record review, review of a South Dakota Department of Health (SD DOH) complaint intake report, interview, and policy review, the provider failed to ensure one of one closed record sampled resident (1) who resided in the enhanced care unit (ECU, a secure memory care unit) had not been involuntarily secluded by one of one complainant (H) and one of one anonymous staff person (I). Findings include: 1. Review of the SD DOH complaint intake report received on 10/2/24 revealed: *Complainant H assisted anonymous staff person I on an unspecified date when resident 1 "was having behaviors." -Complainant H stated "she [complainant H] grabbed resident [1] by the arm and redirected him back to his room. When they [complainant H and anonymous staff I] got back to his room [resident 1] got physical with staff. Staff then locked resident in his room by holding the door shut." *A telephone message was left by the surveyor for complainant H on 10/29/24 at 3:45 p.m. requesting a call back to discuss the complaint. Complainant H did not return the surveyor's call by the end of the survey on 10/30/24. Review of resident 1's closed record revealed: *His admission date was 4/22/24 and he was 69	S 838	In an effort to meet Quality of Life 44:70:09:09(4) all employees will be assigned and required to complete additional Abuse and Neglect & Mandatory Reporting training with a signed acknowledgement of completion. The South Dakota State Ombudsman will be providing in-person training on the same topics. All staff will be required to read Edgewood's Abuse and Neglect Policy and Procedure with a signed acknowledgmeent. 10% random audit of MCU resident behavioral incidents will be completed on a weekly basis for 4 months to ensure staff have followed the expected behavioral iinterventions per the residents care plan. Audit information will be reviewed on a monthly basis at community Quality Assurance Meeting for input and recommendations. Audit to be performed by RN.	12-14-24 12-14-24

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S 838	Continued From page 7 years old. -He resided in the ECU. *His diagnoses included early onset dementia with sundowning (late afternoon and/or early evening occurence of dementia-related behavior) . -His documented behaviors included agitation, sleeplessness, hallucinations, wandering, aggression towards staff, inappropriate urination, inappropriate interactions with female residents, and refusing staff assistance to complete activities of daily living such as medication administration and bathing. *Additional diagnoses included expressive aphasia (a language disorder that affects an individual's ability to communicate) and urinary incontinence which was added to his diagnosis list after admission. *Resident 1 was discharged from the ECU on 10/21/24 to different assisted living memory care unit. Telephone interview on 10/30/24 at 8:30 a.m. with anonymous staff I regarding the complaint intake above revealed: *On an undisclosed date anonymous staff I had responded to sounds coming from a female resident's room. -Anonymous staff I found resident 1 pulling the occupant of that room out of her bed. *Complainant H came to that same room to help anonymous staff I after resident 1 was not able to be redirected out of that resident's room. -After removing resident 1's hand from the room's occupant, anonymous staff I and complainant H each took one of resident 1's arms and physically assisted him back to his own room. Resident 1 was agitated and combative towards staff during that time. *The two staff exited resident 1's room leaving	S 838		

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S 838	Continued From page 8 him alone. *Complainant H held resident 1's door shut to prevent him from leaving until he "calmed down." -The door continued to be held shut for "about 15-20 minutes." *Anonymous staff I had not known who approved the practice of secluding resident 1 in his room by holding the door shut. but this same intervention had occurred more than one time. Interview on 10/30/24 at 12:45 p.m. with administrator A and clinical services director B regarding the above complaint revealed: *They were not aware of any resident-to-resident incidents that had been initiated by resident 1. *They had not known of any instance when resident 1 was involuntarily secluded related to his behavior. -Involuntary resident seclusion was not an accepted behavioral intervention for any resident. *All staff received mandatory initial and ongoing training concerning resident rights, resident abuse, neglect, and exploitation as well as trainings specific to working with residents who have dementia and how to appropriately manage those residents with challenging behaviors. Review of the provider's revised May 2023 Resident Dignity policy revealed, "Restraints: Residents have the right to be free from coercion and restraint. Edgewood does not promote restraints or the use of assistive devices with possible restraining qualities."	S 838		