

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/10/2026
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NAME OF PROVIDER OR SUPPLIER WALNUT VILLAGE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 613 WALNUT STREET YANKTON, SD 57078
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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 3/10/26. The areas surveyed were elopement and resident care. Walnut Village, Inc was found not in compliance with the following requirements: S165 and S443.	S 000	Resident 1 was moved out of facility on 10/9/2025. Exit Door Policy has been updated to prevent future elopements. All staff have gone through training by the Administrator on their first shift after the policy change occurred and future employees will be educated within their first 2 weeks of employment.	
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: Based on South Dakota Department of Health (SD DOH) facility's reported incident (FRI), policy review, observation, and interview, the provider failed to follow the facility's policy for responding to door alarms to ensure the safety of all residents. Findings include: 1. Review of the 12/11/25 SD DOH FRI revealed: *On 9/15/25 at 3:02 p.m. resident 1 exited Walnut Village through the northwest door and walked south on Cedar Street. *The facility's door alarm was activated and cleared improperly by medication aides (MA) E, F, and G.	S 165	Changes to the policy include going go the exit door when activated to see whom has exited the area and staff will then assess whether the resident is alert and oriented to remain outside unattended or staff will assist residents back into the appropriate area of the facility or remain with the resident while the resident is outside. The administrator will be responsible for continued testing of the policy and will test door alarms responses with a minimum test of once per month per shift occurring. Failure to properly follow the exit door policy will range from reeducating employee up to immediate termination of employment.	3-25-26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Josh Blom

TITLE

Administrator

(X6) DATE

3/30/2026

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S 165	Continued From page 1 *MAs E, F, and G were reprimanded verbally, and all staff were being re-educated when they worked their next scheduled shifts. 2. Observation and interview on 3/10/26 at 11:50 a.m. with administrator A and director of nursing (DON) B in the DON's office with an iPad revealed: *The facility was equipped with a camera system. *There were cameras at the front door, the northwest exit, and in the common areas of the facility. *The southwest exit did not have a functional camera. *Each staff member carried an iPad and has access to the cameras. *When an exit door was opened, an audible alarm was triggered and the name of the door was displayed on the iPad. -The audible alarm chimed every minute until the door alarm was cleared. -The door alarm displayed on the iPad screen remained on the screen until the staff cleared the alarm. -The alarm was cleared by the staff tapping the screen of the iPad on the displayed door alarm and clearing the alarm. -The staff could access the facility's cameras in one application (app), view the door, and then clear the door alarm in a second app on the iPad. *Administrator A went and opened the northwest door and an alarm triggered on the iPad. *The staff were expected to go to the door that alarmed and look outside for any residents who may have exited the building. -The staff were to pay close attention to the two west exit doors (north and south) since those doors were not frequently used by the residents. *The front door of the facility was used the most by residents and visitors coming and going.	S 165		

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S 165	<p>Continued From page 2</p> <p>*The staff used the cameras on the iPad to view the front door to see who is coming or going and then reset the door alarm.</p> <p>3. Observation on 3/10/26 at 1:00 p.m. with administrator A and an iPad revealed: *Administrator A and this surveyor exited the southwest exit and an alarm triggered on the iPad. *The staff responded to the door alarm, came to the southwest exit, and looked outside within ninety seconds of the door alarming.</p> <p>4. Observation and interview on 3/10/26 at 3:27 p.m. of the northwest exit door revealed: *This surveyor opened the door and stood in the stairwell for two minutes. *No staff came to the door to look outside. *This surveyor walked to the front nurses' station where MAs C and D were working. *They were asked if the northwest door had alarmed, and they both stated they did not see an alarm. *MA C took an iPad to the northwest door and tested the alarm. *When the door was opened, an alarm triggered on the iPad.</p> <p>5. Interview on 3/10/26 at 3:35 p.m. with MA C and D regarding the door alarms revealed: *The front door gets used a lot by the residents and visitors. *They used the cameras on the iPad to check the front door. *They did not go to the front door and look outside every time there was a door alarm.</p> <p>6. Interview on 3/10/26 at 3:55 p.m. with administrator A regarding the door alarms revealed:</p>	S 165		

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S 165	Continued From page 3 *He agreed that the staff were not going to the front door and looking outside for each door alarm. *He guaranteed the northwest door triggered an alarm when this surveyor opened the door. *He agreed that the staff should have gone to the northwest door and looked outside. 7. Review of the re-education provided from 9/16/25 to 9/19/25 revealed: *The staff were re-educated on the exit doors locking /alarming policy, and the elopement policy. *MA D signed the training on 9/16/25 *MA C was not employed at that time. 8. Review of the exit doors locking/alarming policy revealed: **Policy statement: It is the policy of Walnut Village Inc. to provide safety and security to all residents who reside within the facility. Walnut Village Inc. will follow specific exit door locking and alarming procedures as a means of providing safety and security." **Procedure: 1. Walnut Village Inc.'s exterior doors will be unlocked at 6:00am and remain unlocked until 9:00pm. All exterior doors will be locked from 9:00pm until 6:00am. While doors are locked, they will be alarmed. 2. Walnut Village Assisted Living facility will provide safety and security to residents with cognitively impairment. Residents will have their won private apartment while being able to socialization [socialize] in gathering areas when employees are available to monitor the area. a. The front door of the [facility] will be de-alarmed while [the] administrator is in his office to monitor the exit site. While [the] administrator is out of his office, the door will be	S 165		

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S 165	Continued From page 4 closed and alarmed. b. The door to the sitting/dining room will be open from 7:00am to 9:00am, 10:15am to 1:00pm, and 5:00pm to 7:00pm to allow for increased socialization. At least one staff member will be in this room during the designated times to monitor cognitively impaired residents and ensure they remain at the facility. 3. Whenever door alarms sound, staff are instructed to determine which door alarm was activated and go to that exit door to see who has exited the area. They will assist cognitively impaired residents back into the appropriate area of the facility. 4. The administrator and/or registered nurse of the facility will determine appropriate apartment occupancy when evaluating resident admission. This will be done by assessing and evaluating the resident prior to admission. 5. All residents, family and staff will be educated on the purpose and process of locking, alarming, and de-alarming all doors." 9. Review of MA C's employee record revealed: *She was hired at the facility on 1/6/26. *She completed the policy review and quiz for door alarms and elopement on 1/6/26. *She reviewed all education on 1/15/26 when she completed orientation.	S 165	Resident 1 was moved out of facility on 10/9/2025. Resident Assessment Policy has been updated and DON, R/N, and LPN have implemented new assessment guidelines to include "assessment will be completed initially upon admission, thirty (30) days post admission, with any significant change in condition, and annually." DON will monitor effectiveness of policy changes to ensure change in conditions are being evaluated timely. The DON will report to effectiveness of the new policy to the Administrator monthly for one year to ensure changes in condition are being properly identified and care plans are being updated timely	
S 443	44:70:05:07 Care Of A Resident With Cognitive Impairment Each facility shall use a validated screening tool for evaluation of a resident's cognitive status upon admission, yearly, and after a significant change in condition. This Administrative Rule of South Dakota is not	S 443		3-23-26

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S 443	<p>Continued From page 5</p> <p>met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review and interview, the provider failed to assess a resident's cognitive status after one of one sampled resident (1) had a significant change in condition.</p> <p>Findings include:</p> <p>1. Review of the 12/11/25 SD DOH FRI revealed: *On 9/15/25 at 3:02 p.m. resident 1 exited Walnut Village through the northwest door and walked south on Cedar Street. *The door alarm was activated and cleared improperly by medication aides (MA) E, F, and G. *MAs E, F, and G were reprimanded verbally, and all staff were being re-educated when they worked their next scheduled shift. *Resident 1 was found two blocks west after leaving Walnut Village. *Resident 1 had fallen and was sent by ambulance to the emergency room (ER) to be assessed for injuries.</p> <p>2. Review of resident 1's 12/20/24 annual evaluation of care needs revealed: *She was admitted to the facility on 12/30/21. *She had a diagnosis of Alzheimer's disease with early onset. *Her cognitive and psychosocial evaluation of orientation indicated the resident was frequently forgetful or confused and needed substantial staff assistance to orient her to person, place, and/or time. -"[Resident 1's] memory and level of forgetfulness has worsened significantly over the past year. Staff and family attempt to reorient during these times but often times [resident 1] becomes tearful and frustrated ..."</p>	S 443		

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S 443	<p>Continued From page 6</p> <p>*She had a 12/20/24 Brief Interview for Mental Status (BIMS) assessment score of 9, which indicated her cognition was moderately impaired.</p> <p>*Registered nurse (RN) H conducted resident 1's BIMS assessment documented her as a score of 7, which indicated severely impaired.</p> <p>-RN H's notes indicated, "BIMS testing completed and resident demonstrated worsening memory and inability to recall. She looked around her apartment when asked the month, day, and year looked at the calendar on her wall but was unable to correctly identify date/month/year. This is reflected in her score of 7 as compared with score from one year ago that was 12."</p> <p>*Resident 1 ambulated (walked) with no assistive device but had a walker in her apartment if she needed it.</p> <p>*She was independent with toileting needs and was usually continent of bladder and was continent of bowel.</p> <p>*She did not have a history of falls or require any fall risk interventions.</p> <p>3. Review of resident 1's nursing progress notes from 12/20/24 to 10/9/25 revealed: *On 12/20/24 at 6:30 p.m. "RN [RN H] completed resident's annual assessment. Care plan has been reviewed and updated to reflect increase in resident's care needs, especially related to orientation and mental status. [Resident 1's] memory has declined significantly as compared with nursing assessment from one year ago. Please continue to provide reassurance, orientation, and reminders to [resident 1] so she continues to attend meals, activities and completes her daily cares." *On 3/31/25 at 2:38 p.m. "[Resident 1] walked into RN's office at 11:50a.m. holding a pen stating that she needs help and that she needs to call her [sister name]. RN [RN H] asked what was</p>	S 443		

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S 443	<p>Continued From page 7</p> <p>wrong and she states, {'I don't know what happened this morning, but I can't remember anything, I can't write, and I can't ...'} as she begins to cry. RN [RN H] places call to her sister [sister's name] and handed phone receiver to [resident 1] and she says to [sister's name], {'I don't know what happened, but I can't remember'} then she becomes tearful and starts crying. [Sister's name] visits briefly with [resident 1] as she is at a medical appointment [appt] and states when she is done at this appt she will come by. [Sister's name] comes to WVAL [Walnut Village Assisted Living] and visits at length with RN [RN H] about the decline in [resident 1's] memory and [resident 1] calling her confused, not knowing who she is, and [resident 1] often calling asking where her car is, if her husband is coming to pick her up, or that no one ever comes to see her. [Sister's name] is very supportive and calming for [resident 1]. She will take [resident 1] to her scheduled appt with [name of certified nurse practitioner] at [name of provider] on 4/2/25. [sister's name] states she is in frequent communication with sons about the changes/decline in her memory/statue."</p> <p>*On 5/30/25 at 3:12 p.m. "[Resident 1] has been packing up her belongings today and informed RN [RN H] that she will be moving to a house in Wynot, Nebraska. RN [RN H] entered apartment to find baskets and bags packed with her personal items. RN [RN H] reoriented her and informed her that her sons had not provided notification of a move from WVAL so she would need to stay here for the weekend ..."</p> <p>*On 5/30/25 at 3:34 p.m. "[Resident 1's] sister [sister's name] visited [resident 1] today about 11:00am and came to RN's [DON B] office asking if [resident 1] was moving out. RN [DON B], asked for clarification and [sister's name] proceeded to say that [resident 1] had removed</p>	S 443		
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S 443	<p>Continued From page 8</p> <p>all of her knick knack from her two shelves as well as some of her clothes and photos and placed them into baskets. [Resident 1] told [sister's name] that she was moving out. RN [DON B] verified that facility had no intention or awareness of [resident 1] moving. RN [DON B] and [sister's name] then spent time visiting with [resident 1] who was tearful and had no idea why she packed her belongings after breakfast. [Resident 1] eventually calmed down and agreed to go for a walk outside"</p> <p>*On 6/13/25 at 6:46 p.m. "[Resident 1] went to convenient care tonight, She is being treated for a UTI [urinary tract infection]. Please be sure to encourage her to drink lots of water. Nurse will administer antibiotics as soon as we receive them from pharmacy."</p> <p>*On 6/15/25 at 9:00 p.m. "Resident [1] went out Cedar S [south] door and walked around the building looking for her husband. Resident [1] is claiming that she is 61 years old and her husband is 64. Resident [1] is very confused and having a hard time understanding."</p> <p>*On 6/16/25 at 11:28 a.m. "Placed call to [name of doctor] office in find out results of culture and if the Cipro [ciprofloxacin] 250 mg [milligram] po BID [by mouth twice a day] antibiotic that [resident 1] started on 6/13/25 for UTI was the right one. Received fax that urine culture grew mixed growth and the current antibiotic should be finished. If still experiencing symptoms after completion to call and have her reevaluated."</p> <p>*On 6/16/25 at 11:33 a.m. "RN [DON B] followed up with [resident 1] this morning. Her sister, [sister's name] was present in her apartment during the visit. [Resident 1] does not recall going to the clinic on Friday nor does she know what she did over the weekend (son [son's name] visited). [Resident 1] agrees that her bladder is better and she is not having to go to the bathroom</p>	S 443		

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S 443	<p>Continued From page 9</p> <p>as often. She denies pain with voiding and lower back pain stating, 'that was better yesterday.' [Resident1] is alert and visits politely with RN [DON B] and [sister's name], denies any concerns, and smiled during conversation. She has no needs or requests at this time. RN [DON B] explained her walking out Cedar S door last evening looking for her husband and [resident 1] does not recall this. [sister's name] quickly stated '[resident 1] you know that [husband's name] died right?' to which [resident 1] stated 'yes but sometimes I still want him here.' After discussion, RN [DON B] stated need to call [son's name] which [sister's name] and [resident 1] agreed was acceptable. RN [DON B] contacted [sons name] with an update and he voiced understanding and appreciation. Will continue to evaluate and keep open communication with family."</p> <p>*On 7/22/25 at 7:39 p.m. "[Resident 1] was confused and thought she was leaving tomorrow morning, she has clothes packed sitting on her windowsill, I reminded her she lived here and helped her to start to put them away. If you see her trying to leave, please help remind her she lives at WV [Walnut Village].</p> <p>*On 7/23/25 at 1:38 p.m. "RN [RN H] follow up with resident today after noting staff's documentation about [resident 1] packing up her belongings. Today [resident 1] attended both meals and eaten well. She state 'I have a bad cold' as she talks and says 'I lost my voice.' [Resident 1] does not comment or reference leaving WVAL today for does she talk about her family. RN [RN H] notes [a] laundry basket of clothing and items packed and at the foot of her bed but no further packing up of items noted. [Resident 1] has visited pleasantly with other residents and has been walking in the hallways. Will continue to monitor. [Resident 1] is currently sleeping while sitting in her recliner chair."</p>	S 443		

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S 443	<p>Continued From page 10</p> <p>*On 8/1/25 at 1:24 p.m. "[Resident 1] has been experiencing increased confusion and tearfulness in the late afternoon hours between around 4pm and 8pm. She has repeatedly verbalized worry about her son [son's name] being deceased by suicide, her husband [husband's name] being drunk in a bar, waiting for "him" to come pick her up from work, and her not able to get out to her 5-acre garden. She has repeatedly packed up some of her personal belongings in her laundry basket and going through her purse. She has had her insurance cards and items out of her wallet scattered about on her bed, dresser, and table next to her chair. She was not able to verbalize where she was at but thought she was in Norfolk or Omaha. Staff provides frequent reassurance and orientation. Staff has assisted [resident 1] with putting away her personal items she packs up and trying to distract her with outdoor walks, scheduled activities and helping her get started putting puzzles together. RN [RN H] noted this morning resident had numerous facial hairs to her chin that typically she notices and asks for tweezers to remove. She had not mentioned these so [the] staff took tweezers and assisted her with removing these. She allowed staff to 'pluck' the whiskers as she did not want to do it herself. She was tearful at breakfast but ate well and returned to her apartment and rested in her recliner chair. [Resident 1]' sister [sister's name] came to RN [RN H] and provided her with updates of [resident 1] behaviors. [sister's name] knows of [resident 1] concerns about her son [son's name] as she tried to re-orient [Resident 1] earlier this week that [son's name] was OK and he was to call [resident 1] to assure her. [sister's name] said 'she's stuck on that right now' and stated she communicates with [resident 1's] son [son's name] and from that communication and his visits here he is aware of [resident 1's]</p>	S 443		

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S 443	<p>Continued From page 11</p> <p>worsening memory. [sister's name] questions how well [resident 1] is sleeping. [Resident 1] has continued to attend all three meals most days, reads the newspaper in her apartment and takes short walks in the hallways. RN [RN H] asked [resident 1] if she was feeling OK and she said 'my voice is gone.' She frequently has a hoarse voice. When asked, [resident 1] denies any urinary pain, frequency, itching, or burning with using the bathroom. Will continue to monitor and update care plan to ensure care needs are met." *On 8/6/25 at 4:34 p.m. "[Resident 1] presented to RN's [DON B] office and spent approximately 35 minutes with RN [DON B]. RN [DON B] and [resident 1] sat in RN'S office, walked the facility and ended [up] in apartment 114. During [the] conversation, [resident 1] said 'I've got to find my parents', 'my sister [sister's name] and [name] have got to come home soon,' and she referenced driving her car. RN [DON B] attempted to reorientate [reorient her] by explaining her deceased family members and that she no longer drives. [Resident 1] could not comprehend this information. [Resident 1] spoke of 'the girls' needing a ride home, going to the casino three weeks ago and having everything taken from her, living in Omaha, needing her parents, denied having children, questioning [son's name] going 'to the hills to take care of the snow' and explaining that her husband would be back for her. [Resident 1] was stoic/emotionless during [the] conversation. RN [DON B] attempted to redirect [resident 1], provide comfort and reassurance, provide safety and explain reserved apartment and [resident 1] agreed to rest in her recliner for a little bit. After interaction, [resident 1] returned to RN'S [DON B] office and was then greeted by [staff initials] RN [RN H] who assisted with reorientation, redirection, and affirmation of safety. Will continue to monitor mood, behavior,</p>	S 443		

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NAME OF PROVIDER OR SUPPLIER WALNUT VILLAGE, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 613 WALNUT STREET YANKTON, SD 57078		
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S 443	Continued From page 12 agitation, and needs." *On 8/19/25 at 5:46 p.m. "RN [RN H] received phone call from resident's son [sons name] today at 2:09pm as he was asking 'how is my mom doing since her appointment yesterday and are you seeing slippage in her health?' RN [RN H] updated [son's name] with the pain and difficulty with walking that [resident 1] is experiencing today and informed him of the interventions to promote comfort. [Son's name] asked a number of questions about his mother's memory, social engagement, physical abilities, and hygiene. He states that he was here this past Sunday and noticed his mom was quiet and didn't say much but the staff and other residents greeted her and she smiled and responded. He went on to say that he has noticed increased confusion, with the phone calls he receives from his mom and most often the calls late afternoon/evening. RN [RN H] did confirm that [resident 1] is more confused and more difficult to re-direct after 4pm and that she is typically speaking of people from the past or looking for her car, deceased husband, or her deceased sister [sister's name]. [Son's name] questioned if AL [assisted living] is still appropriate level of care for his mom to which RN [RN H] confirmed that it is but it is getting closer to a higher care level need especially if [resident 1's] confusion worsens and safety concerns if she starts walking out of the facility. [Son's name] states that he has been in discussion with his brothers about the changes with [resident 1] and they have noticed the overall decline. [Son's name] states that on Sunday when he was here, [resident 1] was able to tell that his daughter was someone she should know but was not able to call her by name and [son's name] states that had she not been told by [son's name] that was her granddaughter [resident 1] would have not known. These are things that [son's name] is	S 443		

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S 443	Continued From page 13 really starting to notice more with his mom. When questioned if the family has started looking at other facilities for [resident 1] [son's name] says they have been in contact with [name of nursing home] as they do not want to move [resident 1] to Lincoln or Omaha as that would take away the opportunity for [resident 1's] sister [sister's name] to see her and [son's name] is also concerned about [resident 1's] finances long term. [Son's name] states that [name of nursing home] was asking for information but he was not sure if he should have that sent to them at this time or wait to see how things continue for his mom. RN [RN H] suggested making sure that [resident 1] is on the waiting list at [name of nursing home] so that in the event something changes rather quickly or unexpectedly then they would be aware of the family's interest. As requested, RN [RN H] reviewed with [son's name] details of [resident 1's] daily schedule and care provided by staff. [Son's name] was thankful for the 25 minute phone conversation and will continue to keep open communication with WVAL. *On 8/22/25 at 1:17 p.m. "RN [RN H] has been receiving communication from sons [son two's name] and [son three's name] the last couple of days and WVAL has faxed information as requested by sons to two different AL facilities in Lincoln, NE [Nebraska]. Son [son three's name] visited [resident 1] today and commented "can't believe the change over the last two months since I was here." He went on to say that he notices significant change/decline with his mom's memory and cognition. He states that he and his brothers hope to have a new facility chosen and move to occur by the end of September." *On 9/12/25 at 3:10 p.m. "RN [DON B] received a call from [resident 1's] son, [Son's name], stating 'we've all been thinking about this a lot and it's with a heavy heart that we have to do this, but it's	S 443			

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S 443	<p>Continued From page 14</p> <p>the right thing now for [resident 1] and the family ... she will move to Lincoln the first week of October.' [Son's name] proceeded to explain that 'they' ([resident 1's] sons) plan to come to Yankton Oct. [October] 9th to pack her stuff and take her to a facility in Lincoln to be closer to the boys and 'give [sister's name] a break.' [Son's name] plans to come to Yankton Sept. [September] 30th to attend [resident 1's] appt with [name of physician] so they can talk about the transition. [Son's name] has visited with [sister's name] about this but has NOT visited with [resident 1] about it. RN [DON B] accepted information and thanked [son's name] for the opportunity to care for his mother. [Son's name] commented that this transition will be very hard for everyone but now is the best time. Will continue to assist with coordination of care as needed."</p> <p>*On 9/15/25 at 5:42 p.m. [Resident 1] exited Cedar North at 3:02pm and was found on the ground by 5th and Broadway. She is still in the emergency room at this time being evaluated due to a sore wrist and hip as well as a laceration to her forehead. Please notify the supervision phone when you hear an update. Also, we MUST check ALL door alarms EVERY TIME!"</p> <p>*On 9/15/2025 at 8:04 p.m. "[Resident 1] returned form the ER [emergency room] tonight about 6:55pm. She has steri strips [a bandage] above her eyebrow and to her tight cheek. These should be left on and not removed. [Resident 1] also has a wrist splint to her right wrist, this is to stay on during the day and throughout the night. [Resident 1] has her necklace call light in place. Please continue to check on her and ensure she is comfortable and offer her PRN [as needed] Tylenol if she is awake and tearful or wincing or complaining of any pain. Please be sure to check on her throughout the night and if [Resident 1] is</p>	S 443		

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S 443	Continued From page 15 anxious or wandering, please call the supervisor phone or if you have any questions or concerns." 4. Review of resident 1's 9/4/25 revised care plan revealed: *Her behavior interventions included: -The staff to provide cognitive stimulus and positive redirection due to progression of Alzheimer's dementia. [Resident 1] benefits from staff reminders/invitations to meals and facility activities to ensure she attends. -The staff will orient [resident 1] to the date, time, and next scheduled activity/event by verbalizing this to the resident or reviewing dates on the calendar or daily newspaper. -The staff will provide reassurance to the resident if she is feeling anxious or worried. 5. Review of resident 1's 12/31/24 care plan revealed: *The following items were added to the care plan from 12/31/24 to 9/4/25. -The staff were to ensure her red cell phone was on the table next to her recliner, plugged in and charging each night. -The staff were to wake her each morning and encourage her to get up and get dressed for the day with a clean outfit, and ensure her hair was combed and her face was washed. - The staff were to remind her of the time, and that breakfast was at 8 a.m. - The staff were to ensure she removed her hearing aids, placed them in the charger for the night, and that the charger was plugged in and charging her hearing aids. 6. Interview on 3/10/25 at 3:50 p.m. with administrator A revealed: *After the elopement on 9/15/25 and resident 1's return from the hospital there should have been	S 443			

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S 443	<p>Continued From page 16</p> <p>an assessment of resident 1's cognitive status. *He agreed that resident 1 had increased memory loss from the last annual assessment. *They did not complete an assessment of resident 1's cognitive status since the last annual assessment.</p> <p>7. The provider did not have a policy addressing when the staff were to complete an assessment of a resident's cognitive status after the resident had significant change in their condition.</p>	S 443		