ORIGINAL

PRINTED: 03/27/2013
FORM APPROVED

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
	54874	A. BUILDING ______ B. WING ______	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAYMAN COURT ASSISTED LIVING FACILITY	4101 WEST CAYMAN STREET SIOUX FALLS, SD 57107

(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 Surveyor: 22452 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 from 3/18/13 through 3/20/13. Cayman Court Assisted Living Facility was found not in compliance with the following requirements: S305, S331, S352, S353, and S642.	S 000	Addendums noted with an asterisk per 4/29/13 telephone to facility administrator. KR/SDDOH/JJ	
S 305	44:70:04:05 Employee health program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Rule is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure one of six sampled employees (A) had a health evaluation completed for freedom from communicable disease. Findings include: 1. Review of employee A's personnel file revealed: *A 6/7/12 hire date. *There was no documentation a health evaluation had been completed by a licensed health care professional within fourteen days of being hired.	S 305	Records were obtained from employee mailbox. All health surveilance paperwork for new employees shall be kept in a locked filing cabinet by facility nurse until completed, then sent to human resources to be placed in employee file within 14 days of hire.	3/27/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley [signature] RN, Administrator
TITLE
(X6) DATE 4/3/13

STATE FORM 021199 7LBS11 If continuation sheet 1 of 6

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S 305	Continued From Page 1 Interview on 3/19/13 at 12:15 p.m. with the administrator regarding employee A revealed: *There was no documentation a health evaluation had been completed. *She should have followed up the licensed health evaluation had been completed.	S 305	*Employee A's health evaluation has been completed and is in her file. Both the administrator and the licensed nurse have been educated. Administrator/Human Resources will monitor compliance health evaluations are completed within the fourteen day time frame. The administrator will report findings to QA on a quarterly basis. KR/SDDOH/JJ	
S 331	44:70:04:10 Tuberculin screening requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin or blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing is not necessary if documentation is provided of a previous positive reaction. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin or blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease. This Rule is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure the two-step tuberculin (TB) skin testing had been completed within fourteen days of being hired for one of six sampled employees (A). Findings include:	S 331	Documentation of tuberculin screening, the 2nd step, was completed by the facility nurse at the time of hire. Facility nurse will continue to complete tuberculin screenings of new employees within 14 days of hire. Documentation will be kept in nursing file cabinet, locked, until completed, then sent to Human Resources to go in employee file, effective immediately.	3/27/13

ag [signature] 4/3/13

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S 331	Continued From Page 2 1. Review of employee A's personnel file revealed: *A 6/7/12 hire date. *The first TB screening test had been completed on 6/7/12. *There was no documentation a two-step TB screening test had been completed. Interview on 3/19/13 at 12:15 p.m. with the administrator regarding employee A revealed she: *Confirmed there was no documentation a two-step TB skin screening had been completed. *Should have followed up the two-step TB screening had been completed.	S 331	*Employee A's two-step tuberculin testing has been completed and is in her employee file. The administrator and licensed nurse have been educated. The Administrator/Human Resources will monitor compliance tuberculin skin testing is completed on all new employees within the fourteen day time frame. The administrator will report to QA on a quarterly basis. KR/SDDOH/JJ	
S 352	44:70:04:13 Restricted admissions The facility shall also provide a form developed, by the department, to the resident's physician, physician assistant, or nurse practitioner prior to admission, yearly, and after a significant change of condition containing the following information: (1) The facility name; (2) The optional services the facility is licensed to provide; (3) The signature of administrator or authorized representative and date signed; (4) The residents name; (5) The physician, physician assistant, or nurse practitioners signature and date signed; and (6) The physician, physician assistant, or nurse practitioners printed name. This Rule is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the	S 352		

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S 352	Continued From Page 3 provider failed to ensure the South Dakota Department of Health (SD DOH) optional service form was completed for two of two sampled residents (1 and 3) on an annual basis. Findings include: 1. Review of resident 1's care record revealed: *A 6/14/06 admission date. *An annual optional service form had not been completed. 2. Review of resident 3's care record revealed: *A 11/3/08 admission date. *An annual optional service form had not been completed. 3. Interview on 3/19/13 at 11:00 a.m. with the administrator revealed she had completed the optional service form on admission. She had not done those forms on an annual basis.	S 352	facility administrator will continue to complete the optional service form on residents upon admission. Administrator will complete the optional service on all residents annually at the time of their annual physician assessments. 4/5/13 [signature] *Resident 1 and 3 have had an optional service form completed. The licensed nurse has been educated on the optional service form. The administrator will report the findings to QA on a quarterly basis. KR/SDDOH/JJ	4/5/13
S 353	44:70:04:13 Restricted admissions 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 Rule is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure a validated cognitive screening tool (memory test) was completed upon admission and on an annual basis for three of three sampled residents (1, 2, and 3). Findings include: 1. Review of resident 1's care record revealed: *A 6/14/06 admission date.	S 353		

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S 353	Continued From Page 4 *There was no documentation an annual cognitive screening evaluation had been completed. 2. Review of resident 2's care record revealed: *A 6/26/12 admission date. *There was no documentation a cognitive screening evaluation had been completed upon admission. 3. Review of resident 3's care record revealed: *A 11/3/08 admission date. *There was no documentation an annual cognitive screening evaluation had been completed. 4. Interview on 3/19/13 at 10:30 a.m. with the administrator revealed: *They had not completed any validated cognitive screenings on any residents. *She thought the yearly psychiatric evaluations were enough.	S 353	Facility will use the standardized mini mental state exam as the cognitive screening tool on residents upon admission, annually, and with any significant chang in condition. A mini mental exam will be completed on all residents by April 30th 2013, then annually completed with the facility case manager during annual case service plan reviews. 4/3/13 [illegible] *The administrator will report findings to QA on a quarterly basis. KR/SDDOH/JJ	By 4/30/13
S 642	44:70:07:05 Control and accountability of medications Written authorization by the resident's physician, physician assistant, or nurse practitioner shall be secured for the release of any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication shall be documented in the resident's record, indicating quantity, drug name, and strength. This Rule is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure: *Written authorization had been obtained from	S 642		

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S 642	Continued From Page 5 the physician for the release of medications for one of one sampled resident (4). *Documentation had been completed for the quantity of medications released upon discharge for one of one sampled resident (4). Findings include: 1. Review of resident 4's care record revealed: *A 11/1/12 discharge date. *There was documentation the following medications had been sent with him: -Peridex solution. -Tegretol. -Carbamazepine. -Divalproex. -Flonase nasal spray. -Invega. -Mirtazepine. -Tylenol. *There was no documentation of a physician's order to release the medications. *There was no documentation of the quantity of the above medications that had been released. Interview on 3/19/13 at 9:30 a.m. with the administrator regarding resident 4 revealed: *They had not documented the quantity of medications released with him. *She thought the order they previously had from the physician to send medications with him on outings was enough.	S 642	When discharging a resident, facility nurse will obtain authorization from the primary physician to release current supply of medications with the resident or responsible party/guardian, if appropriate. If authorized by the physician, when releasing medications, the facility nurse will document the medication and quantity being released, effective immediately. [signature] 4/3/13 *Education given to the licensed nurse on this requirement. The administrator will report the findings to QA on a quarterly basis. KR/SDDOH/JJ	4/1/13

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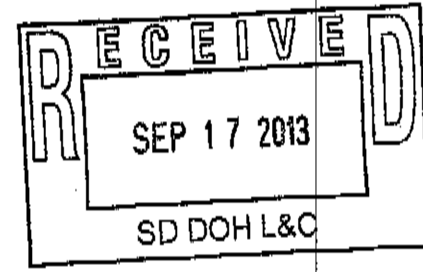
S 000	Compliance Statement Surveyor: 29354 A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted from 8/6/13 through 8/8/13. Areas surveyed included: management, administration, reportable incidents, optional license review, nursing and related care service, medication administration, discharge procedures, staff education, and resident rights. Cayman Court Assisted Living was found not in compliance with the following requirements: S015, S020, S030, S275, S280, S295, S297, S310, S337, S375, S381, S405, S418, S642, S800, and S838.	S 000	Addendums noted with an asterisk per 10/7/13 telephone to facility administrator. JVE/SDDOH/JJ	
S 015	44:70:01:05(1-5) Restrictions on acceptance and retaining A facility shall accept and retain residents in accordance with the follow restrictions: (1) A resident accepted for care by a licensed facility shall be housed within the facility covered by the license; (2) A licensed facility may not accept or retain residents who require care in excess of the classification for which it is licensed; (3) Nursing and personal care personnel essential to maintaining adequate staff may not leave a licensed facility during their tour of duty in the facility to provide services to persons who are not residents of the facility with the exception of providing emergency care on premises contiguous to the facility's property; (4) Each licensed facility that accepts or retains residents suffering from developmental disabilities or mental diseases shall provide facilities and programs consistent with the needs of such residents;	S 015		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], MSW, CSW
TITLE: Administrator
(X6) DATE: 9-17-2013

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S 015	Continued From Page 1 (5) If persons other than residents are accepted for care or to participate in any programs, services, or activities for the residents, their numbers shall be included in the evaluation of central use, activity, and dining spaces; staffing of nursing, dietary, and activity programs; and the provisions of an infection control program. Services provided to such individuals may not infringe upon the needs of the inpatients or residents. This Rule is not met as evidenced by: Surveyor: 29354 Based on interview, record review, and license review, the provider failed to ensure the optional service of cognitively impaired (mental alertness) was on their license to provide care for one of one sampled resident (2) who was cognitively impaired. Findings include: 1. Review of resident 2's care record revealed: *An admission date of 1/3/08. *A diagnosis of mild mental retardation. *A standardized mini-mental state examination (exam) (MMSE) completed on 4/1/13 revealed a score of 20/30. Interview on 8/6/13 at 12:35 p.m. with resident 2 revealed she could not recall what day it was. Interview on 8/7/13 at 9:46 a.m. with the director of nursing (DON) confirmed: *Resident 2: -Had a diagnosis of mild mental retardation. -Had scored 20/30 on the 4/1/13 MMSE exam. -Was considered cognitively impaired. *She was not aware "how licenses for optional services worked." *The facility was not licensed for cognitively impaired.	S 015	*The Administrator of the facility will apply for certification for cognitively impaired individuals to be added to the licence by 9-27-13. DON will update medication training to include cognitively impaired material to ensure all staff recieves education on this population.	9-17-13

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S 015	Continued From Page 2 Interview and MMSE document review on 8/7/13 at 10:45 a.m. with the DON revealed she handed the surveyor a copy of the MMSE. She confirmed: *Scores from the MMSE exam indicated: -26 to 30: Could be normal. -20 to 25: Mild impairment. -10 to 19: Moderate impairment. -0 to 9: Severe impairment. *Resident 2 was at the low end of mild cognitively impaired. *Resident 2 was "More moderately cognitively impaired." Interview on 8/7/13 at 1:45 p.m. with the chief executive officer (CEO) revealed she: *Was unaware resident 2 had a diagnosis of mild mental retardation and had scored 20/30 on the 4/1/13 MMSE exam. *Confirmed the facility did not have cognitively impaired as an optional service on their assisted living license. Review of the current provider's South Dakota Department of Health Assisted Living Center License revealed cognitively impaired was not an optional service they had been approved for.	S 015	*Administrator, Case Manager, and SBH Nursing will form a Cayman Court QA Committee by 9/27/13 and meet every 3 months to complete resident audits on all residents. Each QA member will be assigned 6-8 resident files to review. Administrator will report results to the agency-wide QA committee quarterly. Quarterly audits will be completed consistently throughout the year. JVE/SDDOH/JJ	
S 020	44:70:01:05(6) Restrictions on acceptance and retaining (6) An assisted living center may admit and retain any resident who is able to: (a) Turn self in bed and raise from bed or chair independently or with assist of one staff; (b) Transfer independently or with assist of one staff and do not require a mechanical lift; (c) Complete activities of daily living of mobility or ambulation, dressing, toileting,	S 020		

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S 020	Continued From Page 3 personal hygiene, and bathing with assist of one staff but less than total assist; (d) Feed self with set up, cueing, and supervision; (e) Complete own ostomy or catheter cares; (f) Display normal expected behaviors for condition that do not place self or others at risk; (g) Complete own injections if scheduled or required or provided by nursing staff if assisted living staff allows; (h) Manage cares for his or her own feeding tube, tracheostomy, or peritoneal dialysis; (i) Remains free from the need for restraints, except for admission to a secured unit; (j) Demonstrate no need for skilled services unless provided by contract with a Medicare certified home health agency or assisted living nursing staff for a limited time with a planned end date; (k) Be free from communicable diseases that place other residents or staff at risk; and (l) Maintain conditions that are stable and controlled that do not require frequent nursing care. This Rule is not met as evidenced by: Surveyor: 29354 Based on interview and record review, the provider failed to: *Ensure the appropriate care could be maintained for one of one sampled resident (1) who was over level of care that could be provided in an assisted living center. *Implement safety measure for one of one sampled resident (1) whose actions put him at a high risk for potential danger. Findings include: 1. Review of resident 1's closed care record revealed: *He was non-compliant with medication	S 020	*Effective immediately, prior to admission to the facility, DON and Administrator will complete a full safety assessment on individuals to evaluate if they will require the appropriate level of care for an assisted living center according to ARSD regulations.	9-17-13

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S 020	Continued From Page 4 administration. *His actions and behaviors placed him at danger to other residents and himself. Refer to S838.	S 020	* Effective immediately, safety measures will be implemented to all current residents in the facility through the use of an individualized safety plan that includes a step by step plan for staff to intervene specific behaviors. This will be monitored every 6 months by Administrator, DON, and Case Specialist. *Refer to S838. Administrator, Case Manager, and SBH Nursing will form a Cayman Court QA Committee by 9/27/13 and meet every 3 months to complete resident audits on all residents. Each QA member will be assigned 6-8 resident files to review. Administrator will report results to the agency-wide QA committee quarterly. Quarterly audits will be completed consistently throughout the year. JVE/SDDOH/JJ	* [redacted] JVE/SDDOH/JJ
S 030	44:70:01:07 Reports Each licensed facility shall submit to the department the pertinent data necessary to comply with the requirements of SDCL chapter 34-12 and this article. Each facility shall report to the department within 48 hours of the event any death resulting from other than natural causes originating on facility property such as accidents, abuse, negligence, or suicide; any missing resident; and any allegation of abuse or neglect of any resident by any person. Each facility shall report the results of the investigation within five working days after the event. Each facility shall also report to the department as soon as possible any fire with structural damage or where injury or death occurs; any partial or complete evacuation of the facility resulting from natural disaster; or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours. This Rule is not met as evidenced by:	S 030		

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S 030	Continued From Page 5 Surveyor: 29354 Based on record review, interview, and policy review, the provider failed to investigate and accurately report to the South Dakota Department of Health (SD DOH): *A resident (1) found unresponsive that had resulted in a hospitalization. *An allegation of an inappropriate interaction between two of two sampled residents (1 and 2) and one unidentified minor reported by the police outside of the facility. *An elopement of resident 1. Findings include: 1. Review of confidential information provided to the SD DOH complaint coordinator regarding resident 1 revealed: *He was found non-responsive in a motel room apparently near death on 6/20/13. *He was taken to a hospital and admitted to an intensive care unit (ICU) and placed on an insulin drip. Review of resident 1's closed care record revealed: *There was no documentation to the SD DOH regarding the above. *There was no incident report or investigation for the above. 2. Review of confidential information provided to the SD DOH complaint coordinator regarding an allegation of an inappropriate interaction resident 1 had towards resident 2 revealed: *There was no documentation to the SD DOH regarding the above. *There was no report or investigation for the above. 3. Review of resident 1's closed care record progress notes revealed on:	S 030	* Resident 1 was inappropriately discharged from the facility on 6-19-13 Effective immediately, the facility will follow the ARSD rules for discharge planning. Discharge policy will be reviewed annually by Administrator. * Effective immediately, the facility will Follow ARSD rules on reporting abuse and neglect to DSS * and SDDOH JVB/SDDOH/JJ and also report the results of the investigation to SDDOH within 5 working days after the event. Staff will complete incident/Accident Reports according to SBH policy. The Administrator will submit reports regarding incidents/accidents as required and policy will be reviewed annually * by HR and the Administrator. JVB/SDDOH/JJ * Effective immediately, the facility will consistently report to SDDOH if there is an elopement of any resident of the facility. This policy will be reviewed annually * by HR and the Administrator. JVB/SDDOH/JJ	9-17-13 * [redacted] JVB/SDDOH/JJ * [redacted] JVB/SDDOH/JJ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	54874	A. BUILDING ______ B. WING ______	08/08/2013

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S 030	Continued From Page 6 *5/30/13 at 8:09 p.m. "Left at 8 p.m. to visit a friend after asking a pizza delivery man for a ride." *5/31/13 at 5:39 p.m. "Hasn't returned from his visit yet." *5/31/13 at 6:40 a.m. "After notifying administrator of (resident 1's) absence, staff began an attempt to locate at 6:45 a.m." *6/12/13 at 7:58 p.m. "Did not return by 5 p.m. so an attempt to locate was done on him and police came out as 5:30 p.m. to take a report. At 6 p.m., staff received a call from security at the downtown library stating that there had been an "incident" between resident and another patron at the library. Resident returned with police at 6:30 p.m. and police informed staff that resident had been making inappropriate advances toward a 17 year old girl at the library." *There was no documentation to the SD DOH regarding the above. *There was no report or investigation for the above. Interview on 8/6/13 at 11:10 a.m. with case specialist A revealed: *That no incidents had ever been reported to the SD DOH. *That there was no incident reports for the above findings. Telephone interview on 8/6/13 at 2:45 p.m. with the administrator revealed: *The facility had never had any reportable incidents. *There was no documentation that was submitted to the SD DOH regarding any type of reportable incident. Interview on 8/7/13 at 9:46 a.m. with the director of nursing (DON) revealed she: *Had visited by phone yesterday (8/6/13) with the	S 030	*Administrator, Case Manager, and SBH Nursing will form a Cayman Court QA Committee by 9/27/13 and meet every 3 months to complete resident audits on all residents. Each QA member will be assigned 6-8 resident files to review. Administrator will report results to the agency-wide QA Committee quarterly. Quarterly audits will be completed throughout the year. On 9/24/13, Administrator provided Cayman Court Staff with copies of the following policies and/or Operational Guidelines: Transfer Discharge Notice/ Planning, Counseling for Termination of Residency, Termination of Residency due to Level of Care change, Notification of Resident Condition Changes, medication for Resident Absences, Mandatory Reporting by Facility, and Abuse and Neglect Policy. These are available via the communication binder and kept in the RA office. A quiz is being developed by the Administrator to verify comprehension of the policies, to include how to complete the incident/ (continued on Page 8)...	

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S 030	Continued From Page 7 administrator and was informed that no information needed to be reported to the SD DOH regarding the alleged allegation between residents 1 and 2. *Confirmed the administrator had not reported the above to the SD DOH. Interview on 8/7/13 at 10:45 a.m. with case specialist A revealed: *Any staff member who witnessed an incident was suppose to fill out an incident report. *She was not aware of any incidents that had been reported to the SD DOH. *She felt there should have been more documentation between the alleged incident on 6/19/13 of resident 1 and 2. Interview on 8/7/13 at 1:45 p.m. with the chief executive officer revealed she was unaware that incidents were to be reported to the SD DOH. Review of the provider's revised 10/6/08 Mandatory Reporting by Facility policy revealed: *"Whenever requested by the Department of Health, Cayman Court will submit reports as required: -Any missing patient or resident. -Any allegation of abuse or neglect of any patient or resident by any person. The facility shall also report the results of the investigation to the Department of Health within five working days after the event. -Resident to resident incidents (verbal and physical) are reportable when the accused resident has a history of incidents with other residents." Review of the provider's revised 1/21/08 Incidents/Accidents policy revealed: *"Whenever an occurrence or event leads to unintentional or consequences and an	S 030	accident reports. RA's, Case Manager, Administrator, and SBH Nursing may complete incident/accidents. SBH Nursing will monitor reports consistently. The quiz is required to be completed by all staff. JVE/SDDOH/JJ	

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S 030	Continued From Page 8 unfortunate happening to a resident, visitor, or staff member on the grounds of Cayman Court an Incident/Accident Report must be completed. -The Administrator will submit reports regarding incidents/accidents as required. Review of the 10/6/08 Southeastern Behavioral HealthCare Operational Guideline for Mandatory Reporting by a Facility revealed "Any allegation of abuse or neglect of any patient or resident by any person. The facility shall also report the results of the investigation to the Department of Health within five working days after the event."	S 030		
S 275	44:70:04:01 Governing body Each facility operated by limited liability partnership, a corporation, or political subdivision shall have an organized governing body legally responsible for the overall conduct of the facility. If the facility is operated by an individual or partnership, the individual or partnership shall carry out the functions in this chapter pertaining to the governing body. This Rule is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, policy review, and license review, the governing body failed to ensure the facility had been operated in a manner: *To investigate and accurately report to the South Dakota Department of health reportable incidents. *That provided the oversight of an administrator who was responsible for the daily management of the facility. *For one of one sampled resident (2) who required care in excess of the provider's license.	S 275	*Effective immediately the facility will follow ARSD rules on reporting abuse and neglect to DSS *and SDDOH and also report the results of the investigation to SDDOH within 5 working days after the event. * Interim Administrator (case specialist A) has been notified of her job duties. Effective 9-13-13, a new Administrator that meets job qualifications is in place to oversee the daily management of the facility. * The Administrator of the facility will apply for certification for cognitively impaired individuals to be added to the licence by 9-27-13.	9-17-13 JVE/SDDOH/DJ * [redacted] JVE/SDDOH/DJ * [redacted] JVE/SDDOH/DJ

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S 275	Continued From Page 9 *Discharge planning to have occurred for one of two sampled (1) residents who had been discharged. *That a quality assurance program had been implemented to identify failures in system processes. *For care plans to address resident identified needs including behaviors and staff interventions. *That documentation of all residents needs had been identified and addressed. *For correct documentation of medication administration. *Of notification to the physician during one of one resident (1) mental and physical changes. *That the physician notification and physician's orders were followed for one of one sampled resident (1). *Staff had not been properly trained to care for residents with mental illness. *To follow physicians' order for mood altering medications. *To notify physician with a change in condition with elevated blood sugars. Findings include: 1. Review of resident 1's complete closed care record revealed: *He had been discharged without a physician's order. *He had not received the correct dosage of medication. *The physician had not been notified of elevated blood sugars. *His care plan had not included interventions for his increase in behaviors. Refer to: S015, S020, S030, S275, S280, S295, S297, S310, S337, S375, S381, S405, S418, S642, S800, and S838.	S 275 A policy review will be included in the QA review and completed by QA Committee every 3 months. JVE/SDDOH/JJ	*Effective immediately, discharge planning has been reviewed by administration and will be followed at each discharge. *This policy will be reviewed annually by Administrator. *Effective 9-13-13, Administrator is a member of the agency's QA committee that ensures all CARE files will be randomly pulled for quality assurance. Administrator will report findings to CC staff at least quarterly. *Case Specialist will include specific interventions for identified behaviors on each residents case service plan. Staff will be made aware of where this document is located in Lotus Notes so they can review and implement interventions. Effective 9-24-13, a CARE team will meet weekly to review client behaviors and treatment plans. Case service plans are reviewed every 6 months.	* [redacted] JVE/SDDOH/JJ * [redacted] JVE/SDDOH/JJ * [redacted] JVE/SDDOH/JJ

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S 275	Continued From Page 9 *Discharge planning to have occurred for one of two sampled (1) residents who had been discharged. *That a quality assurance program had been implemented to identify failures in system processes. *For care plans to address resident identified needs including behaviors and staff interventions. *That documentation of all residents needs had been identified and addressed. *For correct documentation of medication administration. *Of notification to the physician during one of one resident (1) mental and physical changes. *That the physician notification and physician's orders were followed for one of one sampled resident (1). *Staff had not been properly trained to care for residents with mental illness. *To follow physicians' order for mood altering medications. *To notify physician with a change in condition with elevated blood sugars. Findings include: 1. Review of resident 1's complete closed care record revealed: *He had been discharged without a physician's order. *He had not received the correct dosage of medication. *The physician had not been notified of elevated blood sugars. *His care plan had not included interventions for his increase in behaviors. Refer to: S015, S020, S030, S275, S280, S295, S297, S310, S337, S375, S381, S405, S418, S642, S800, and S838.	S 275 by the QA Committee. A policy review will be included in the QA review and completed by QA Committee every 3 months. JVE/SOOOH|JJ	*Effective 9-24-13, information on mental illness, medications, and interventions will be made available to all Staff via a training manual that will be located in the RA office. Administrator will provide staff with trainings on caring for mentally ill individuals at least quarterly. * Effective immediately physician orders will be followed for mood altering medications. Policies will be reviewed annually * by the QA Committee. A Policy review will be included in the QA review and completed by QA Committee every 3 months. JVE/SOOOH|JJ * Effective immediately, the Physician will be notified of any change in condition with elevated blood sugars. Policies will * be reviewed annually	* [redacted] JVE/SOOOH|JJ * [redacted] JVE/SOOOH|JJ * [redacted] JVE/SOOOH|JJ

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S 280	Continued From Page 10	S 280		
S 280	44:70:04:02 Administrator The governing body shall designate a qualified administrator to represent the owner or governing body and to be responsible for the daily overall management of the facility. The administrator shall designate a qualified person to represent the administrator during the administrator's absence. The governing body shall notify the department in writing of any change of administrator. This Rule is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure the daily overall management of the facility was maintained. Findings include: 1. Review of the provider's undated administrator job description revealed: *"The Assisted Living Administrator is responsible for the overall planning, developing and implementation of Cayman Court the Assisted Living program for persons who are homeless and have a mental illness." *Essential job functions included: -Provide individual and group supervision. -Provide training. -Provide ongoing formal and informal evaluation of staff. -Plan, develop, and implement initial training and ongoing in-service training/education programs for staff. -Schedule staff coverage. -Provide structure and leadership. -Provides direct education and consultation to families, agencies and individuals concerned with mental illness.	S 280	* Effective 9-13-13, a new Administrator is overseeing the daily management of the facility. Administrator was provided, in writing, a job description that outlines specific duties that include new expectations that are client-centered. CEO has notified the State of the administrative change in writing on 9-12-13.	9-12-13.

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S 280	Continued From Page 11 -Facilitate communication between Cayman Court and all other staff to ensure all staff understand and support the Cayman Court in meeting consumers needs. -Ensure the availability of qualified back-up staff coverage for staff absences. -Assist in development of facilities policies, community planning, and purchasing of necessary items for continuation of daily programming. -Provide emergency on-call coverage. -Participate in planning, development, and implementation of varied case management services program to best meet the needs and interests of Cayman Court residents and their families. -Ensure Cayman Court staff were providing quality, comprehensive services. -Provided crisis intervention services for the severely mentally ill/consumer. -Assist consumers in filling out forms as needed. -Develop and carry out an individual treatment program for each resident. -Write necessary reports and prepare documents for other agencies as needed. Interview on 8/7/13 at 8:30 a.m. with case specialist A revealed: *The current administrator had gone on maternity leave. Her last day in the facility was on 6/21/13 and would not be back to work for at "least a month." *The director of nursing (DON) was going to be the DON/administrator. *On 6/24/13 case specialist A was informed she would have to be the administrator. Her responsibilities would include the day-to-day operations of the facility. *The DON would cover the medical end as the administrator.	S 280	*The governing body will monitor the administrator to ensure compliance and that expectations are met. Administrator meets with CEO for supervision every 2 weeks, or as needed. JVE/SDDOH/JJ	

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S 280	Continued From Page 12 Interview on 8/7/13 at 9:46 a.m. with the DON revealed: *No one had informed her she was the administrator. *She was responsible for the medical end of the facility. *Case specialist A was the acting administrator as far as she knew. Interview on 8/7/13 at 12:02 p.m. with the chief executive officer (CEO) revealed: *Case specialist A was the acting administrator. *She was unaware case specialist A and the DON were confused about who the acting administrator was. *She had not notified the South Dakota Department of Health in writing about who the acting administrator would be. *She was unaware the above was required. Review of the provider's revised 10/06/08 Administrator policy revealed: *"Facility will designate a person to serve as Administrator." *"CEO of Southeastern Behavioral HealthCare will designate an Administrator per ARSD (Administrative Rules of South Dakota). Refer to S015, S020, S030, S275, S280, S295, S297, S310, S337, S375, S381, S405, S418, S642, S800, and S838.	S 280		
S 295	44:70:04:04 Personnel training The facility shall have a formal orientation program and an ongoing education program for all personnel. This Rule is not met as evidenced by:	S 295	*Effective 9-24-13, the facility will provide an ongoing education program for all personnel through providing a training manual with information on mental illness, medication, and	9-24-13

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S 295	Continued From Page 13 Surveyor: 29354 Based on interview and record review, the provider failed to offer an ongoing education program related to care for all residents with mental illness for one of eight sampled resident (1). Findings include: 1. Review of the provider's on going in-service training program revealed: *A March 2013 in-service on Residents with unique needs: involuntary committal process. *A 5/13/13 in-service on Residents with unique needs. There was no documentation to indicate what had been reviewed. *There were no further in-service training on how to care for residents with mental illness. A telephone interview on 8/6/13 at 5:30 p.m. with former employee resident assistant (RA) B revealed: *On the evening of 6/19/13 following an alleged incident between residents 1 and 2 he had a conversation with the chief executive officer (CEO). The CEO had informed him: -All Cayman Court staff had not performed there jobs up to standard. -"Staff did not know what they were doing out there." -They had not received enough training. -The alleged incident between residents 1 and 2 had occurred because staff had not known what they were doing. -She was partially responsible for the staff being under trained. *RA B confirmed: -He had received "sub par" training for mental illness. -He thought resident 1's care plan was "not up and available." -No one had told him how to "work interventions	S 295	interventions that will be located in the RA office. Staff will be required to read identified sections each shift. Administrator will schedule staff trainings on various topics related to the care for residents at least quarterly. These trainings will be posted so staff is aware. *Administrator and SBH Nursing will develop quizzes that coincide with training in order for Administrator and SBH Nursing to verify comprehension of material presented. All staff will be required to complete quizzes for their personnel files. JVE/SDDOH/JJ	

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S 295	Continued From Page 14 with resident 1." Interview on 8/7/13 at 9:46 a.m. with the director of nursing confirmed the provider had talked about staff training, and she stated they needed to do more staff training. Interview on 8/7/13 at 1:45 p.m. with the CEO revealed: *Cayman Court had been built for mental illness and homeless people. *She had met with the administrator and case specialist A on 6/18/13 to review additional training for the staff. *The administrator had not come to her and requested additional training for her staff. *The agency had provided the required all staff training. *The CEO was responsible to provide ongoing staff education, but it also was the administrator of each programs responsibility to pursue staff training. Review of the provider's April 2009 Resident Assistant job description revealed: *Report any resident abuse/neglect or suspected abuse/neglect for residents immediately to the administrator. *RAs should have knowledge of: -Procedure for documenting resident behavior and progress. -The physical and psychological needs of the mentally ill. *RAs would be able to: -Deal with potentially aggressive behavior. -Prioritize crisis situations. Review of the provider's 1/21/08 Ongoing Staff Training Operational Guideline revealed: *"Notice of continuing education and training opportunities will be posted for all staff."	S 295		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAYMAN COURT ASSISTED LIVING FACILITY	**4101 WEST CAYMAN STREET SIOUX FALLS, SD 57107**

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S 295	Continued From Page 15 *"Staff will be asked to identify their interests at regular intervals and particularly at the time of individual performance appraisals." Review of the provider's 1/21/08 Orientation and Training Operational Guideline revealed: *"Orientation and training will be provided to employees before they are assigned responsibilities." *"The program will consist of training in tasks of the position/job description."	S 295		
S 297	44:70:04:04 Personnel training Additional personnel education shall be based on facility identified needs. Current professional and technical reference books and periodicals shall be made available for personnel. This Rule is not met as evidenced by: Surveyor: 29354 Based on observation and interview, the provider failed to ensure current professional and technical books and periodicals were made available to personnel for a facility identified with residents with mental illness needs. Findings include: 1. Review of reference and technical books available for staff to use included: *Diagnostic and Statistical Manual of Mental Illness. *PDR, Family Guide to Prescription Drugs. Interview on 8/7/13 at 12:02 p.m. with case specialist A confirmed the above manuals were the only two available for personnel to use.	S 297	* current professional and technical reference books and periodicals will be ordered by 9-27-13 and periodically updated by Administrator and DON.	9-27-13

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S 297	Continued From Page 16	S 297		
S 310	44:70:04:06 Admissions or retention of residents The governing body of the facility shall establish and maintain admission, transfer, and discharge policies, with written evidence to assure the residents admitted to and retained in the facility are within the licensure classification of the facility or its distinct part. The facility may admit and retain, on the orders of a physician, physician assistant, or nurse practitioner, only those residents for whom it can provide care safely and effectively. This Rule is not met as evidenced by: Surveyor: 29354 Based on record review and interview, the provider failed to initiate and document discharge planning for one of one sampled resident (1). Findings include: 1. Review of resident 1's complete closed care record revealed no documentation at the time of his discharge according to their policy. Refer to S381 and S838.	S 310	*Discharge planning has been reviewed by administration and, effective immediately, will be followed at each discharge. Policies will be reviewed annually* by the QA Committee. JVE/SDDOH/JJ *A policy review will be included in the QA review and completed by QA committee every 3 months. The Administrator will complete the discharge paperwork and Case Manager will complete discharge plan to ensure that a resident is discharged to an appropriate place. JVE/SDDOH/JJ	9-17-13
S 337	44:70:04:11 Care policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Rule is not met as evidenced by:	S 337		

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S 337	Continued From Page 17 Surveyor: 29354 Based on closed record review and interview, the provider failed to maintain acceptable standards of practice for one of one sampled resident (1) to ensure: *Physician orders were followed for mood altering medications. *The physician had been notified with a change in condition. Findings include: 1. Review of resident 1's physician's admit orders to Cayman Court transcribed on 4/15/13 revealed he was to receive: *Clozapine (Clozaril) 100 milligrams (mg) po (by mouth) AM & 350 mg po HS (hour of sleep). *Blood sugar test (FSBS) QID (four times a day) & prn (when needed.) *If blood sugars greater than 400 notify PAC/CNP (physician assistant certified/certified nurse practitioner). *Review of the undated medication administration record (MAR): -Clozaril (medication used for schizophrenia in severely ill patients unresponsive to other therapies) 100 mg tablet (tab), give 1 tab every morning. There were circles around the 17 through the 22nd. -Clozaril 100 mg tab, give three tabs po at bedtime. There were circles around the 16, 17, and 18th. There was no documentation on the MAR why the medication had been circled. On the MAR dated 4/18/13 was "order rewritten to match cards." -Clozaril 200 mg tab. Give 1 1/2 tabs po at bedtime (total 300 mg). There were circles around the 18, 19, and 20th. There was no documentation on the MAR why the medications had been circled. -Metformin (medication used to lower glucose levels) 1000 mg, give 1 tab po at 8 a.m. and 5	S 337	* Effective immediately the facility will follow ARSD regulations and follow Physicians orders for mood altering drugs. Policies will be reviewed annually* by the QA Committee. A policy review will be included in the QA review and completed by QA Committee every 3 months. JVE/S00H/JT * Effective immediately the physician will be notified * by facility personnel JVE/S00H/JT of changes in condition for each resident. Policies will be reviewed annually. *A policy review will be included in the QA review and completed by QA Committee every 3 months. On 9/24/13, Administrator provided Cayman Court Staff with copies of the following policies and/or Operational Guidelines: Transfer Discharge Notice/ Planning, Counseling for Termination of Residency, Termination of Residency (continued on Page 18a)...	9-17-13 * [redacted] JVE/S00H/JT

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S 337	Continued From Page 17 Surveyor: 29354 Based on closed record review and interview, the provider failed to maintain acceptable standards of practice for one of one sampled resident (1) to ensure: *Physician orders were followed for mood altering medications. *The physician had been notified with a change in condition. Findings include: 1. Review of resident 1's physician's admit orders to Cayman Court transcribed on 4/15/13 revealed he was to receive: *Clozapine (Clozaril) 100 milligrams (mg) po (by mouth) AM & 350 mg po HS (hour of sleep). *Blood sugar test (FSBS) QID (four times a day) & prn (when needed.) *If blood sugars greater than 400 notify PAC/CNP (physician assistant certified/certified nurse practitioner). *Review of the undated medication administration record (MAR): -Clozaril (medication used for schizophrenia in severely ill patients unresponsive to other therapies) 100 mg tablet (tab), give 1 tab every morning. There were circles around the 17 through the 22nd. -Clozaril 100 mg tab, give three tabs po at bedtime. There were circles around the 16, 17, and 18th. There was no documentation on the MAR why the medication had been circled. On the MAR dated 4/18/13 was "order rewritten to match cards." -Clozaril 200 mg tab. Give 1 1/2 tabs po at bedtime (total 300 mg). There were circles around the 18, 19, and 20th. There was no documentation on the MAR why the medications had been circled. -Metformin (medication used to lower glucose levels) 1000 mg, give 1 tab po at 8 a.m. and 5	S 337	due to Level of Care Change, Notification of Resident Condition Changes, Medication for Resident Absences, Mandatory Reporting by Facility, and Abuse and Neglect Policy. These are available via the communication binder and kept in the RA office. A quiz is being developed by the Administrator to verify comprehension of the policies, to include how to complete the incident/accident reports. RA's, Case Manager, Administrator, and SBH Nursing may complete incident/accident reports. SBH Nursing will monitor reports consistently. The quiz is required to be completed by all staff. JVE/SDDOH/JJ	

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S 337	Continued From Page 18 p.m. (1 tab = 1000 mg). There were circles around the 8 a.m. dose from the 17 through the 21st. There were circles around the 5 p.m. dose from 17 through the 20th. -There was no documentation on the MAR why the medications had been circled. Review of May 16 through May 30, 2013 blood sugar log revealed blood sugar readings over 400 had occurred twice. June 1 through June 19, 2013 blood sugar readings over 400 had occurred three times. There was no documentation the PAC/CNP had been notified during the above. (Normal blood sugar readings were 80 to 112.) Interview on 8/6/13 with licensed practical nurse D revealed: *The undated monthly MAR was from April 2013. *She did not know why the dates for the Clozaril and Metformin were circled. *She confirmed there was no documentation on the MAR to indicate the above. *She confirmed when a medication was circled it indicated the medication had not been given. Review of the psychiatrist's 5/3/13 documented visit notes with resident 1 revealed: *Increase citalopram (antidepressant) 20 mg, one and a half tabs every morning. *Clozaril 100 mg every morning and 350 mg at bedtime. *Review of the May 2013 and June 2013 MARs revealed: -Citalopram had not been increased until 6/5/13. -He had continued to receive Clozapine 25 mg two tabs by mouth every morning for May and June even though the order had been for 100 mg every morning.	S 337	* A policy will be developed to address QA at the facility by the Administrator and then reviewed by the SBH Governing Board by 9-27-13. Administrator has been added as a member of the agency wide QA Committee on 9-13-13. Administrator report findings to staff at least quarterly. There will be a QA team made up of Administrator, DON, and Case Specialist at the facility.	* [illegible] JVEL[illegible]

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S 375	Continued From Page 19	S 375		
S 375	44:70:04:15 Quality assessment Each facility shall provide for on-going evaluation of the quality of services provided to residents. Components of the quality assessment evaluation shall include establishment of facility standards; review of resident services to identify deviations from the standards and actions taken to correct deviations; resident satisfaction surveys; utilization of services provided; and documentation of the evaluation and report to the governing body. This Rule is not met as evidenced by: Surveyor: 29354 Based on record review, quality assurance (QA) plan review, interview, and policy review, the provider failed to ensure an ongoing quality assurance (QA) program was implemented. Findings include: 1. Review of the provider's QA committee information provided by the facility revealed: *Multiple resident checklists that had been done on 8/24/09, 12/3/09, 10/4/11, 1/8/12, 5/22/12, 6/18/12, 8/14/12, and 5/2013. *There were no policies or procedures for a QA program. *There was no documentation to address who was responsible to implement the QA program or when and how QA meetings would be conducted. Interview on 8/7/13 at 9:46 a.m. with the director of nursing revealed: *The QA committee was agency wide. *She had not been part of the committee. *The provider had not had a QA committee.	S 375		

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S 375	Continued From Page 20 Interview on 8/7/13 at 10:45 a.m. with case specialist A revealed: *The administrator: -Was the only one on the QA committee for the facility. -Would do random checklists for residents. -Had not shared any of the information with the staff. -Had not done the reports quarterly. *She knew the reports needed to be done quarterly. Interview on 8/7/13 at 1:45 p.m. with the chief executive officer revealed she did not know if the facility had a QA committee. Review of the provider's 10/6/08 Quality Assessment policy guideline revealed: *Resident Quality Assessments: -Residents would be given a satisfaction questionnaire annually to fill out. -Those questionnaires would be used to compile information from the residents regarding their care and services. -The administrator would compile the results of the annual satisfaction questionnaire. Those results will be made available to staff and residents. *Clinical Quality Assessments: -Quarterly the administrator, registered nurse, and care specialist would review all residents' charts according to the quality assessment form. -Administrator would keep all QA documentation forms and determine needed changes according to the results. Refer to S015, S020, S030, S275, S280, S295, S297, S310, S337, S375, S381, S405, S418, S642, S800, and S838.	S 375		

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S 381	Continued From Page 21	S 381		
S 381	44:70:04:16 Discharge planning The facility shall initiate planning with applicable agencies to meet identified needs and residents shall be offered assistance to obtain needed services upon discharge. Information necessary for coordination and continuity of care shall be made available to whomever the resident is discharged and to referral agencies as required by the discharge plan. This Rule is not met as evidenced by: Surveyor: 29354 Based on a closed record review and interview, the provider failed to provide and document appropriate coordination of care when discharged from the facility for one of one sampled resident (1). Findings include: 1. Review of resident 1's complete closed care record and multiple staff interviews conducted over the course of the survey revealed: *The resident had been discharged without a physician's order. *There was no documentation discharge planning had been done according to the provider's Transfer Discharge Notice/Planning policy. Review of the provider's 10/6/08 Transfer Discharge Notice/Planning policy stated: *"The facility will provide a resident and/or the resident's representative with a thirty (30) day written notice in advance of an impending transfer or discharge." *"Except as specified below, a resident and/or his/her representative will be given a thirty (30) day advance notice of an impending transfer or discharge from the facility:	S 381	* Effective immediately all residents discharge will be completed according to the facility's Transfer/Discharge Notice/Planning Policy. Staff will be informed of this policy by 9-27-13. Policies will be reviewed annually * by the QA Committee. JVE/SDDOH/JJ *A policy review will be included in the QA review and completed by QA Committee every 3 months. JVE/SDDOH/JJ	9-27-13

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S 381	Continued From Page 22 -The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the transfer. -The safety of individuals in the facility is endangered." *"The resident and/or representative will be provided with the following information: -The reason for the transfer or discharge. -The effective date of the transfer or discharge. -The location to which the resident is being transferred or discharged. -The name, address and telephone number of the state long-term care ombudsman. -The name, address and telephone number of each individual or agency responsible for the protection and advocacy of mentally ill or developmentally disabled individual. -The name, address and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices." *"The administrator is responsible for discharge planning. The discharge planning team shall include the administrator, registered nurse, residents' care specialist, and other members of the team as appropriate." *"The Cayman Court staff shall initiate planning with applicable agencies to meet identified needs. The resident shall be offered assistance to obtain needed services upon discharge." *"The administrator shall provide information necessary for coordination, and continuity of care shall be made available to the discharge site and referral agencies, as required by the discharge plan." Refer to S310 and S838.	S 381		

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S 405	Continued From Page 23	S 405		
S 405	44:70:05:02 Resident care plans and programs The nursing service of a facility shall provide safe and effective care from the day of admission through the ongoing development and implementation of written care plans for each resident. The care plan shall address medical, physical, mental, and emotional needs of the resident. This Rule is not met as evidenced by: Surveyor: 29354 Based on record review, interview, and policy review, the provider failed to implement individualized written care plan for one of three sampled residents (1). Findings include: 1. Review of resident 1's 4/25/13 case service care plan revealed there were no objectives, interventions, outcome/dispositions listed regarding: *His inappropriate conduct toward residents, staff, or outside entities. *Information and interventions for staff to redirect the resident during his inappropriate conduct. Interview on 8/6/13 at 10:00 a.m. with case specialist A revealed: *She had done the case service plan with resident 1 when he had been admitted. *The resident drove the service plan. *The mental health director only wanted positive reinforcement items on the service plan, nothing negative. *Staff had been informed of his behaviors through meetings and talking with each other. *There was no documentation on the service plan about resident 1's behaviors and how staff were to redirect him.	S 405	* Case Service Plans will be updated by Case manager and SDH Nursing JVE/SADOH/JJ to include a nursing assessment in order to address medical and physical needs of each resident. Care Specialist will include specific interventions for identified behaviors on each residents case service plan. Staff will be made aware of where this document is located in Lotus Notes so they can review and implement interventions by 9-27-13. Case Service plans to be reviewed every 6 months or upon residents changes in status/condition by Administrator, DON, and Case Specialist. JVE/SDOH/JJ	9-27-13

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S 405	Continued From Page 24	S 405		

Interview on 8/6/13 at 3:30 p.m. with case manager C revealed:
*He would add information to resident 1's service plan at six months and yearly.
*He would not expect more information on the service plan.
*Service plans were "client driven."
*Each resident would have a behavior plan besides the service plan.

Interview on 8/6/13 at 4:00 p.m. with case specialist A confirmed resident 1 did not have a behavior plan.

Interview on 8/6/13 at 5:30 p.m. with former employee resident assistant B revealed:
*He did not think resident 1 had a care plan that "was available and up and running" for staff to use.
*He had not been informed or educated on what interventions to use with the resident during his inappropriate behaviors.

Interview on 8/7/13 at 9:46 a.m. with the director of nursing confirmed there were no interventions listed on resident 1's service plan directing staff on how to deal with his inappropriate behavior.

Interview on 8/7/13 at 10:45 a.m. with case specialist A revealed:
*Information for staff should have been on resident 1's care plan to direct them on how to deal with his inappropriate behavior.
*She did not know how many staff looked at each resident's service plan.

Review of the provider's 10/23/08 Case Service Plan guideline revealed:
*"A case service plan will be completed by the Primary Care Specialist within 30 days of moving

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S 405	Continued From Page 25 to Cayman Court." *"The Case Service Plan will address medical, physical, mental and emotional needs of the resident." "The Primary Care Specialist will establish a schedule for services based on the case service plan and inform the Resident Assistants of assistance needs." *"Residents will not be forced to accept a service as long as it is evident they are capable of meeting that need independently."	S 405		
S 418	44:70:05:03 Resident care The facility shall have documentation that assures that the individual needs of residents are identified and addressed. This Rule is not met as evidenced by: Surveyor: 29354 Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (1) had follow-up documentation for elevated blood sugars, physician's orders, care planning, and discharge planning. Findings include: 1. Review of resident 1's complete closed record revealed: *The PAC (physician assistant certified) and/or CNP (certified nurse practitioner) had not been notified during episodes of elevated blood sugar readings. *The service care plan had not reflected the resident's behaviors or staff interventions. *Discharge planning had not been completed. Refer to S337 and S838.	S 418 or upon residents changes in status/ condition. JVE/SDDOH/JJ	* Effective immediately, Physician will be notified of changes in elevated blood sugars for residents. Policies will be reviewed annually* by the QA Committee. A policy review will be included in the QA review and completed by QA Committee every 3 months. JVE/SDDOH/JJ * Effective immediately, Case Service Plans for all residents will include specific interventions for identified behaviors for each resident* [redacted] [redacted] CSP's will be reviewed by Administrator, DON, and Case Specialist every 6 months. *All residents discharges will be completed according to the facility's Transfer Discharge Notice/ Policy planning immediately. Policies reviewed annually.	9-17-13 * [redacted] JVE/SDDOH/JJ * [redacted] JVE/SDDOH/JJ

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	54874	A. BUILDING ______ B. WING ______	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAYMAN COURT ASSISTED LIVING FACILITY	4101 WEST CAYMAN STREET SIOUX FALLS, SD 57107

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S 642	Continued From Page 26	S 642	*S418 continued:	
S 642	44:70:07:05 Control and accountability of medications Written authorization by the resident's physician, physician assistant, or nurse practitioner shall be secured for the release of any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication shall be documented in the resident's record, indicating quantity, drug name, and strength. This Rule is not met as evidenced by: Surveyor: 29354 Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (1) had: *A physician's order to release medications. *Documentation for the release of medication in his closed care record. Findings include: 1. Review of resident 1's closed care record revealed he had been taken to a motel the evening of 6/19/13. There was no documentation in his care record: *The physician had been notified the resident would be discharged from the facility. *To indicate medications had been sent to the motel with the resident. *For a physician's order to send medication with the resident at discharge. Telephone interview on 8/6/13 at 2:45 p.m. with the administrator regarding resident 1 revealed: *On 6/19/13 all of resident 1's medications were given to case manager C. *She could not remember if the insulin or insulin syringes had been sent with him. *No paper work had been given to the case	S 642	by the QA Committee. A policy review will be included in the QA review and completed by QA Committee every 3 months. JVE/SDDOH/JJ *Effective immediately, physician orders will be obtained in order to release medications to residents upon discharge. The release of medications will then be documented in residents MAR according to policy, and will be dated and signed by staff. DON will provide annual reviews of facility policies for med trained staff regarding the release of medications to residents.	9/7/13

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S 642	Continued From Page 27 manager or resident 1. *Resident 1 had not been given a medication administration sheet or a treatment administration sheet. *Resident 1 just "knew by memory what medications he had to take and when to do his blood sugars." *The physician had not been notified of the above on 6/19/13 nor by 6/21/13. Interview on 8/6/13 at 3:30 p.m. with case manager C revealed: *The nursing department handed him resident 1's medications prior to leaving the facility on 6/19/13 with the resident. The medications included insulin, insulin needles, and the facility glucometer. There had been enough medications for one week. *They had given resident 1 "some type of print out." Interview on 8/7/13 with the director of nursing (DON) revealed: *She was the DON for Southeast Behavioral HealthCare. *She was at Cayman Court about once a week. *She had left the facility prior to resident 1 leaving with case manager C on 6/19/13. *Her expectations would have been: -For a better discharge for resident 1. -The medication and treatment administration records should have been sent with resident 1. -The primary physician and the psychiatrist should have been notified of resident 1 leaving the facility. Review of the provider's undated Using the Medication Administration Record procedure revealed: *" Under certain circumstances, when the administration of medication/treatment is not	S 642	*Policies will be reviewed annually by the QA Committee. A policy review will be included in the QA review and completed by QA Committee every 3 months. JVE/SDDOH/JJ	

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S 642	Continued From Page 28 possible at the correct administration time, the individual who administers medication/treatment will utilize the following approved abbreviations and circle them to record in the appropriate space on the medication administration record: -1. H Resident Hospitalization. -2. TW Resident took medication with. -3. R Resident refused." Review of the provider's revised 7/7/09 Medications for Resident Absences procedure revealed "The nurse, nurse/med (medication) staff will coordinate arrangements for the resident's medications during the planned absence." Review of the provider's revised 11/11/08 Notification of Resident Condition Changes procedure revealed: *"Procedure: To ensure notification of resident condition changes to resident's physician and authorized representative or interested family. *Facility personnel will notify resident physician via telephone, fax or by scheduling a physician visit for resident when/if condition changes. Condition changes include: -The physical, mental, or psychosocial status changes significantly. -The individual resident treatment needs alter significantly. -A decision to transfer or discharge the resident from the facility."	S 642		
S 800	44:70:09:04 Notification when...condition changes A facility shall immediately inform the resident, consult with the resident's physician, physician assistant, or nurse practitioner, and, if known, notify the resident's legal representative or	S 800		

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S 800	Continued From Page 29 interested family member when any of the following occurs: (1) An accident involving the resident that results in injury or has the potential for requiring intervention by a physician; (2) A significant change in the resident's physical, mental, or psychosocial status; (3) A need to alter treatment significantly; or (4) A decision to transfer or discharge the resident from the facility. This Rule is not met as evidenced by: Surveyor: 29354 Based on closed record review and interview, the provider failed to notify the physician with changes in condition for one of one sampled resident (1) who had required medical interventions. Findings include: 1. Review of resident 1's complete closed record revealed: *The physician had seen him once during his admission on 4/16/13 at Cayman Court. *The physician had not been informed of his: -Elevated blood sugar readings. -Missed doses of medication for his diabetes, depression, and schizophrenia. -Antidepressant dosage had not been increased from the previous physician's visit. -Continued increase in inappropriate behaviors. -Discharge on 6/19/13 from the facility. Refer to S838.	S 800	*Effective immediately, the facility will follow ARSD regulations to notify residents and their physician when there is a significant change in the resident's physical, mental, or psychosocial status. Residents will be scheduled with psychiatrist at least quarterly. Policies will be reviewed annually* by the QA Committee. JVE/SDDOH/JJ	9-17-13
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:	S 838		

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S 800	Continued From Page 29 interested family member when any of the following occurs: (1) An accident involving the resident that results in injury or has the potential for requiring intervention by a physician; (2) A significant change in the resident's physical, mental, or psychosocial status; (3) A need to alter treatment significantly; or (4) A decision to transfer or discharge the resident from the facility. This Rule is not met as evidenced by: Surveyor: 29354 Based on closed record review and interview, the provider failed to notify the physician with changes in condition for one of one sampled resident (1) who had required medical interventions. Findings include: 1. Review of resident 1's complete closed record revealed: *The physician had seen him once during his admission on 4/16/13 at Cayman Court. *The physician had not been informed of his: -Elevated blood sugar readings. -Missed doses of medication for his diabetes, depression, and schizophrenia. -Antidepressant dosage had not been increased from the previous physician's visit. -Continued increase in inappropriate behaviors. -Discharge on 6/19/13 from the facility. Refer to S838.	S 800	*S800 continued: A policy review will be included in the QA review and completed by QA Committee every 3 months. On 9/24/13, Administrator provided Cayman Court staff with copies of the following policies and/or Operational Guidelines: Transfer Discharge Notice/Planning, Counseling for Termination of Residency, Termination of Residency due to Level of Care Change, Notification of Resident Condition Changes, Medication for Resident Absences, Mandatory Reporting by Facility, and Abuse and Neglect Policy. These are available via the communication binder and kept in the RA office. A quiz is being developed by the Administrator to verify comprehension of the policies, to include how to complete the incident/accident reports. RA's, Case Manager, Administrator, and SBH Nursing may complete incident/accident reports. SBH Nursing will monitor reports consistently. The quiz is required to be completed by all staff. Facility personnel are responsible for notifying the physician if there is a significant change in the residents's physical, mental	
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:	S 838		

or psychosocial status.

JVE/SDDOH/JJ

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S 838	Continued From Page 30 (4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property. This Rule is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, policy review, license review, and police report, the provider failed to: *Maintain a safe and secure manner free from abuse to the residents by other residents. *Conduct and document a thorough investigation into an alleged sexual incident by a resident (1) to another resident (2). *Ensure safety measures were carried out for one of one resident (1) with diabetes mellitus, mental illness, and lacking of his self awareness of safety. Findings include: 1. Review of confidential information provided to the South Dakota Department of Health complaint coordinator revealed: *Resident 1 had: -Been found non-responsive in a motel room apparently near death the night of 6/20/13. -Been taken to a local hospital on 6/20/13 and had been placed on an insulin drip in the ICU (intensive care unit.) -Been placed at the Human Services Center (HSC) in Yankton following the hospitalization. *An on going investigation of an alleged incident involving a female resident being fondled by a male resident. 2. Review of resident 1's complete closed care record revealed: *An admission date of 4/16/13. *Diagnoses of schizoaffective disorder,	S 838 and S000H JVE/S000H/JJ	* Effective immediately, prior to admission to the facility DON and Administrator will complete a full safety assessment on individuals to evaluate if they will require the appropriate level of care for an assisted Living center according to ARSD regulations. * Effective immediately, the facility will follow ARSD rules on reporting abuse and neglect to DSS* and also report the results of the investigation to SDOH within 5 working days of the event. *the Administrator is responsible for reporting. JVE/S000H/JJ	9-17-13 * [redacted] JVE/S000H/JJ

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S 838	Continued From Page 31 adjustment disorder with mixed behaviors of emotions and conduct, borderline personality disorder, anti social behaviors, and diabetes mellitus - insulin dependent. Review of documentation from a previous health facility revealed: *He had been admitted 19 times to that facility. *He had an extensive psychiatric history. *He had not followed aftercare recommendations and had been noncompliant with medications and monitoring of his blood sugar levels. *Several facilities had refused to admit him related to medical concerns and past behaviors. *He was oriented to person, place, and time. *He had a 10th grade education. *He had high risk issues related to treatment and discharge planning that had included poor follow through with aftercare services, substance abuse issues, noncompliance with medications, and diabetes issues. Review of Cayman Court 4/24/13 Admission Needs Assessment regarding resident 1 revealed: *Referred for services to the assisted living setting to provide structure and support resident 1 needed to increase his independence and to prevent rehospitalization." *"Resident 1 is a severe diabetic. He is insulin dependent and test his blood sugars several times a day." *"Resident 1 denies any mental health issues in his family, however records indicate a history of depression." *"Resident 1 has a long history of misdemeanor thefts. He has been incarcerated several times for theft. However he is not allowed to go to several stores in Sioux Falls until July of 2014 as a result of his thefts." *"Resident 1 completed 10th grade in Rapid City	S 838	* Effective immediately, safety measures will be implemented to all current residents in the facility through the use of an individualized safety plan that includes a step by-step plan for staff to intervene specific behaviors. This will be monitored every 6 months by Administration, DON and case specialist. Staff will practice proper documentation to monitor for increase of behavioral changes in residents. Staff will communicate any changes or significant issues	

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S 838	Continued From Page 32 by his report." *"He has a history of suicidal statements, as well as threats towards others." *"Resident 1 is a 29 year old, never married man with an extensive mental health history." Review of the Standardized Mini-Mental Examination (MMSE) completed on 4/16/13 revealed resident 1 scored 30/30. Review of resident 1's progress notes from 4/23/13 through 6/20/13 revealed on: *"4/23/13 at 8:23 p.m.: "Caught borrowing cigarettes again." *5/1/13 at 8:01 p.m.: "Staff caught him trying to get cigarettes from other residents at least 6 times and also witnessed him try to gain access to several vehicles parked on the street." *5/3/13 at 7:51 p.m.: "Complained several times about his glucose test strips not arriving from the pharmacy." *5/7/13 at 7:43 p.m.: "Involuntarily committed to Avera Behavioral at 4 p.m." *5/9/13 at 12:15 p.m.: "Transferred to HSC. Discharged from Cayman Court." *5/29/13 at 9:00 p.m.: "Arrived at 4:30 p.m. and immediately asking other residents for cigarettes and/or money." *5/30/13 at 7:26 p.m.: "Asking residents for cigarettes and rides during the shift today." *5/30/13 at 8:09 p.m.: "Left again at 8 p.m. to visit a friend after asking a pizza delivery man for a ride." *6/1/13 at 8:50 p.m.: "Another resident reported to staff that resident 1 said he was going to shoot someone with a gun." *6/2/13 at 11:02 a.m.: "After lunch another resident came to the office to notify staff that resident 1 was bothering her for cigarettes." *6/5/13 at 11:15 a.m.: "Continues to be intrusive into others conversations."	S 838	regarding each resident at the change of each shift. *Training on proper documentation of progress notes, Case Service Plans, and incident/accident reports, and individualized safety plans are being developed by Administrator and SBH Nursing, effective immediately. Administrator will provide ongoing training to staff throughout the year. Review of documentation is included in QA Review every 3 months and will be completed by the QA Committee. This committee consists of Administrator, Case Manager, and SBH Nursing. JVE/SDDOH/JJ	

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S 838	Continued From Page 33 *6/5/13 at 7:30 p.m.: "Spent the afternoon walking around the facility and asking various residents for cigarettes and/or money. He continually followed other residents outside on their smoke breaks to ask them for cigarettes and was in the dining area bothering several residents." *6/7/13 at 9:06 p.m.: "Continues to ask visitors and anyone in the facility for rides and cigarettes." *6/9/13 at 12:00 p.m.: "Was disruptive and argumentative amongst staff and other residents." *6/10/13 at 8:07 p.m.: "Was picked up by the Sioux Falls City police and taken to Minnehaha County Correctional facility due to the fact that he had failed to vacate the premises of a local business." *6/12/13 at 12:20 p.m.: "At 8:45 a.m. he ran into middle of road and was trying to flag down people for a ride." *6/12/13 at 12:42 p.m.: "Clubhouse (Southeastern Behavioral HealthCare) staff notified Cayman that resident 1 was kicked out of Clubhouse an hour ago." *6/12/13 at 7:58 p.m.: "At 6 p.m. staff received a call from security at the downtown library stating that there had been an "incident" between resident 1 and another patron at the library. Resident 1 returned with police at 6:30 p.m. and police informed staff that resident 1 had been making inappropriate advances toward a 17 year old girl at the library. The resident left at 7:50 p.m. and gave no notification of where he was headed or when he planned to return. He did not receive his hs (bedtime) meds or insulin." *6/13/13 at 7:34 p.m.: "Was seen at apt (apartment in the facility) 201. Staff reminded him that he is not allowed to ask other residents for cigarettes or money." *6/14/13 at 12:36 p.m.:	S 838		

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S 838	Continued From Page 34 -"Staff had to follow him most of the day due to multiple incidents. He was caught many times harassing and pressuring other residents for smokes, money, etc. There were also many incidents with him trying to get into other residents room without knocking. After realizing that the doors were locked he would then knock until they answered the door then he would try to push his way inside the apartment. He did however enter a female residents room without knocking, staff saw him do this and went down to the room. When staff entered the room the female was in bed sleeping and resident 1 was standing at the foot of her bed." -He followed a staff member into the laundry room and stated "My tongue does very special things to girls and if they can't handle it I wont do it." When staff informed him that this was wrong to say he blocked them in the laundry room and wouldnt let them out." *6/19/13 at 8:18 p.m.: "At 3:45 p.m. staff were advised that inappropriate contact was taking place between resident 1 and resident 2. Staff went to investigate, and saw resident 1 kneeled in front of the other resident, who was seated, and was kissing and touching her. Resident 1 looked up at staff and said "What?" He was immediately separated from the other resident and looked after by staff until police arrived. Police and his case manager came and spoke to him about the incident. He was discharged from the facility and left with his case manager at 5:30 p.m." There was no physician order or documentation that resident 1 had been discharged. *The following evening on 6/20/13 at 8:11 p.m. after resident 1 had be taken to a motel revealed: "At around 5 p.m. resident 1 walked into the front door. I saw him right away and told him to leave now. I walked him back out the front door and told him to go across the street and not to come	S 838		

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S 838	Continued From Page 35 on the property or I would call the police. He was out there sitting on the curb until a taxi came and picked him up." Review of the administrator's progress notes regarding resident 1 from 4/23/13 through 6/17/13 revealed: *4/23/13: "Admitted to Cayman Court. Is able to check his own blood sugars and administer his own insulin safely." *5/2/13: "Denies events that happened yesterday. He then went on to threaten this writer and stated he will sue the facility for deframation of character. Reminded him that he did admit to getting into someone's vehicle when we spoke yesterday but he denies this." *5/9/13: "Transported to Avera Behavioral by officers on an involuntary commitment this afternoon due to threatening behaviors towards other clients and staff. He will not be able to return to Cayman Court due to this behavior and safety of others." *5/29/13: "Arrived to Cayman Court at approximately 1640 this afternoon from Sanford hospital." *6/6/13: "I approached resident 1 this afternoon after getting reports from others that he was harassing a resident for cigarettes. Another resident who was outside smoking at the time, told resident 1 to stay away after resident 1 forced his way into this residents apartment this morning demanding cigarettes. This resident then walked away when resident 1 became verbally abusive toward the resident." *6/11/13: "I received a call on Monday, Jun 10th, 2013 at approximately 1435 from an Officer [name of person] with the Sioux Falls Police Department (SFPD) stating they had resident 1 in custody because he was harrassing businesses in the area near Madison and West." *6/12/13: "At about 12:08 p.m., Detective [name	S 838		

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CAYMAN COURT ASSISTED LIVING FACILITY	4101 WEST CAYMAN STREET SIOUX FALLS, SD 57107

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S 838	Continued From Page 36 of person] from the SFPD called. Detective stated that resident 1 was located at 2200 West Madison apartments when the apartment manager called the police because resident 1 wouldn't stop approaching people and cars and pounding on car doors. He had also been making sexual comments towards women in the vicininty. As a woman came out to get her mail, he began harrassing her and wanted to know if she had an apartment and insisted on going inside the apartment to "really show her what he can do to her." *6/17/13: "This afternoon I received a visit from Officer [name of person] with the SFPD concerning resident 1's living arrangements at Cayman Court. He explained that officers patrolling the area voiced concerns about resident 1 living at the facility and the safety of other clients. He presented the call log with all of the calls involving resident 1. Within the last eight days, the police have been out six times for resident 1 due to disorderly conduct." *6/17/13: "I received serveral phone calls over the weekend regarding resident 1 and his behavior. A female resident called the police on Friday evening after resident 1 continued to harass her. On Sunday, resident 1 was redirected numerous times for harassing other residents, mainly for cigarettes. At 9:39, I was informed by his primary case manager, (case manager C) that he was arrested for a failure to vacate/trespassing." Review of case specialist A's progress notes regarding resident 1 from 4/23/13 through 6/5/13 revealed: *4/23/13: "Initiated a conversation with resident 1 about recent behavior. He has been begging cigarettes from others, and when challenged about this behavior becomes rather threatening." *4/24/13: "Resident 1 was actively involved in	S 838		

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developing his CSP (care plan)."
*4/30/13: "Resident 1 and I met several time today. We initially met as scheduled to focus on some of the concerns that have been relayed to this writer from family members, peers, and other staff. Explained to resident 1 that there have been reports of him asking people for cigarettes, people feeling "scared" of him when he tell them to let him have 1/2 of their cigarettes, family members expressing concerns because he is calling a peer at their home, asking for money and cigarettes. Resident 1 denies that he has done any of these things."
*5/1/13: "At about 2:15 p.m. case specialist and administrator met with resident 1. Resident 1 was informed that we have had numerous complaints from staff, peers, and even family members about his behavior. He was also given 2 weeks to change this behavior, or face the possibility of eviction. He does understand the consequences of continuing his current behaviors."
*5/3/13: "Resident did meet with his doctor."
*5/6/13: "It was reported that he was taking cigarettes from others as well as appearing to intimidate other clients to get cigarettes. Attempted to engage resident 1 in a discussion of this, and he became even angrier, stepping close to CS (case specialist) with hands fisted. Resident 1 continues to be angry, threatening and demanding."
*5/7/13: "Resident 1 continues to be agitated and angry. He is becoming more agitated daily as well as more threatening. Will talk with administrator about the possibility of filing an IVC (involuntary commital)."
*5/7/13: "This writer was made aware that resident 1 had gone to the Clubhouse and was causing a good deal of problems there by a phone call from the 5th street receptionist. She reported to me that resident 1 was smoking in a

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S 838	Continued From Page 38 non-smoking area and had been reported for calling another consumer in a wheelchair a "f****** bitch". I discussed the situation with the administrator and we decided to contact the SFPD on the non emergency line to ask for officer to meet me there and hopefully to escort resident 1 to Behavioral Health. We decided to contact the sheriff's deputy again to file an IVC (involuntary commital)." *5/15/13: "This writer received a phone call from SW (social worker) at HSC. Resident 1 is being discharged from HSC tomorrow. He will be taken to the mission at that time." *5/30/13: "I then reminded resident 1 he was not to ask anyone for cigarettes and money, since it had already been reported to me by a peer that he was bugging me for money last night. *5/31/13: -"When this writer arrived at Cayman this morning, I was informed that a call had been made to SFPD because resident 1 had been gone all night, that he had not notified any staff that he was leaving and had not signed out." -"He (resident 1) arrived back in the building at about 8:10 a.m. The police officer shared with RA (resident assistant) and myself that resident 1 was somewhat agitated and had made statements that concerned the officer. He told us he was concerned for (RA) and my safety at this time." -"Resident 1 asked several other staff for rides, and again left the facility at about 9:20 without signing out, and without any medication. It should be noted that his blood sugar this morning was too high to register on the meter." *6/5/13: "I talked with resident 1 about the concerns which include badgering a female resident for cigarettes telling her "give me a f****** cigarette right now" and pushing his way into another residents apartment demanding cigarettes. The latter incident was witnessed by	S 838		

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S 838	Continued From Page 39 our maintenance man." Review of case manager C's progress notes regarding resident 1 from 5/30/13 through 6/24/13 revealed: *5/30/13: "Met with resident 1 in the hospital. This is now the third time resident 1 has been in the hospital because he is not taking care of his diabetes. Specifically we discussed with resident 1 his only option that can be provided through Southeastern Behavioral HealthCare (SEBH) is to stay at Cayman Court again under the premise of agreeing to contract dealing with his behaviors. Resident agreed to move into Cayman again as long as it was not a move that is permanent." *6/4/13: -"Met with resident 1 in the community. Specifically I received an email from Cayman Court stating that resident 1 is harassing fellow residents and threatening to punch one of the RN's." -"Plan: We will meet later in the week to discuss how he is doing following the Cayman contract and if he is using the anger plan we worked out together." *6/10/13: -"Met with resident 1 in the office where he showed up unannounced. Reminded resident 1 that I will be meeting him at Cayman and he doesn't need to come to 5th Street any more because of the complaints we are receiving." -"Plan: We will meet later in the week to assess symptoms, address noted concerns, and evaluate progress towards goals. Resident 1 will limit his conversations with people if he is only going to make sexual advances." *6/12/13: -"Met with resident 1 in the office where he showed up unannounced. I reminded resident 1 again that he doesn't need to come to the office	S 838		

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S 838	Continued From Page 40 any more. There have been to many complaints about him harassing other clients. I then walked resident 1 out the door and stressed that I will call him at Cayman and we will meet out there as well. Shortly after this I received a call from the support staff stating that a couple of clients had unpleasant encounter with resident 1 right after I walked him out. Resident 1 went around to the front of the building by the Clubhouse entrance and was asking for cigarettes and a ride from multiple people. Resident 1 also supposedly was making unwanted advances to a female client propositioning her for relations. Right after that a staff informed me that resident 1 stopped her in the parking lot begging for a ride. I talked to resident 1 as soon as he returned to Cayman and he denied all of the above." -"Plan: Resident 1 will not come back down to the office anymore trying to speed up the process." *6/14/13: -"Met with resident 1 in the community." -"Plan: We will meet in one week to assess symptoms, address noted concerns, and evaluate progress towards goals. Resident 1 will stay away from places that he doesn't have permission to use their land." *6/19/13: -"Arrived to meet with resident 1 at Cayman for our scheduled appointment. I was notified that resident 1 was caught in a compromising position with another resident in the laundry room. I was also informed that the police were called. Shortly after the police arrived the head of nursing and the CEO arrived. I then was able to have a discussion with both of them going over the options we had available for resident 1. After looking up the state statutes the officers decided that the mental capabilities of both individuals are similar and that there is no ground to arrest resident 1.	S 838		

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S 838	Continued From Page 41 -I suggested that if I could arrange a motel room for the night would he (resident 1) be interested. Resident 1 then informed me that he is done with Cayman and he wants out of there. -I then talked with the CEO and head of nursing about how he was very much on edge. I did inform the CEO and Caymans head of nursing about what we discussed. It was agreed upon that SouthEastern Behavioral HealthCare will pay for one night at a motel and he will be terminated from Cayman. -Finally I helped resident 1 bring his belongings that he could fit in a backpack and picked up the rest of his medications from the nurses station to the motel. I helped resident 1 check into the motel. -Plan: We will meet in one week to assess symptoms, address noted concerns, and evaluate progress towards goals. Resident 1 will follow the rental market to help him see what it is costing in the market." *6/21/13: "I received a call from (name of person) who was calling from Sanford ICU about resident 1. Resident 1 was brought in unresponsive because of unmanaged insulin levels. Resident 1 was placed on a insulin drip to attempt to stabilize his levels. As of the end of the day Friday resident 1 was not stable enough to leave the ICU. I was able to plead my case to (name of person) that resident 1 was and is a danger to himself. I was able to go over his recent history covering the last few weeks. Resident 1 is showing a consistent path of being arrested or he is in the hospital for his diabetes. (name of person) agreed with me and called the supervising doctor who also agreed and they put in a petition for resident 1 to be placed at HSC." *6/24/13: Discharge Summary: -"He tends to have difficulty following rules and regulations and also becomes somewhat threatening toward staff and others.	S 838		

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S 838	Continued From Page 42 -Resident 1 was offered multiple supports and he initially agreed to use them. However did not follow through with the contract he signed. He also continued to not manage his diabetes which caused him to be in the hospital. Resident 1 frequently lied. Resident 1 did not receive support from our agency and failed at our highest level of care and is at this time being discharged. -Resident 1 is currently hospitalized at Human Service Center in Yankton and will stay there until they determine a more appropriate placement. However at this time our agency is not capable of serving this individual." 3. Review of resident 2's care record revealed: *She had a diagnosis of mild mental retardation. *She had scored 20/30 on the MMSE on 4/1/13. *6/19/13 at 7:52 p.m. progress notes revealed: "At 3:45 pm, another resident informed staff that a male resident was having inappropriate contact with resident 2. Staff got to the laundry room and saw resident 2 seated on a chair and the male resident kneeling in front of her and touching and kissing her. The two were immediately separated and police were called. The police came and spoke to resident 2 about the incident, and she informed them that he had kissed her and put his hands up her shirt and under her bra. The cops asked her if this was unwanted, to which she responded "yes." She also told them that she had informed the other resident that the contact was unwanted, but he continued until staff arrived." *There was no documentation on the 5/16/13 case service plan regarding resident 2 being a vulnerable adult. *Review of the 6/20/13 case specialist 's progress note revealed: -"Resident 2 shared that she believes 'this man is a bad man.' She also states he made her 'very uncomfortable, but he didn't hurt me'."	S 838		

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S 838	Continued From Page 43 Interview on 8/6/13 at 12:35 p.m. with resident 2 revealed: *She could not remember the date of the above incident. *It took awhile for her to answer the questions. *She could not remember a recent episode where someone had touched her inappropriately. *Her only concern was to get more drumsticks (ice cream) to eat. Telephone interview on 8/6/13 at 2:45 p.m. with the administrator confirmed: *The day of the alleged incident on 6/19/13 between residents 1 and 2 had revealed: -Two staff members and she were in the medication (med) room. A resident came and said resident 1 was making out with resident 2 in the laundry room. She went to the laundry room and found resident 2 sitting on a chair. Resident 1 was kneeling between her legs, he had his head under resident 2's shirt and was kissing her breasts. She told resident 1 to quit. He stated "I didn't do anything." The police were called. One staff member stayed with resident 2, and one staff member stayed with resident 1. When resident 2 was by herself she was asked what happened. Resident 2 stated she was in the laundry room. I know I'm not his girlfriend. Denied any previous encounters had occurred with resident 1. Resident 1 had tried to talk to her in her own room. He had tried to kiss, had kept kissing her, and had fondled her breasts. He had kissed her breasts. Resident 2 had told him to stop but he had not. The police came. Everyone was seperated. Police spoke with everyone. -Administrator called the director of nursing (DON). The DON had come to the facility. The DON had called the chief executive officer (CEO). -The CEO had spoke with the police and had	S 838		

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informed the police residents 1 and 2 had the same mental capacity. They were consenting adults.
-The CEO had told her "It wasn't like resident 2 was raped."
-The police had informed her they were confused due to the fact they (residents 1 and 2) were mentally ill, were consenting adults, and police did not feel comfortable arresting resident 1 due to conflicting reports between upper management and Cayman Court staff.
-The police would "make out some type of report", send the report off, and then determine what steps if any would be taken.
-The administrator told the CEO and case manager C resident 1 could not stay. Extra staff had been called in to monitor resident 1.
-The CEO and case manager C made the decision to take resident 1 to a motel. Resident 1 agreed to that. Money was taken from Cayman Court petty cash to pay for the motel room.
-All of resident 1's meds were given to case manager C.
-She could not confirm if the insulin or insulin needles were sent with him. But she had given case manager C the facilitys glucometer to take with them.
-No paper work had been sent with them.
-Resident 1 "knew what meds he took" but no MAR/TAR was sent with him.
-No discharge instructions regarding medications or follow up care were given.
-The physician was not called.
-A physician's order to discharge resident 1 was not obtained.
-Resident 1 was given a discharge letter.
-Case manager C then left the facility with resident 1.
-The administrator then went home.
*Further telephone interview at the above time with the administrator revealed:

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S 838	Continued From Page 45 -An incident on 6/14/13 between resident 1 and 8 had occurred. Resident 1 was found in resident 8's room. Police were notified but they could not do anything about the above. -During resident 1's stay at the facility he was only seen once by the psychiatrist for med management and no med changes were done. The pyschiatrist did not feel it was the medication. Meds would not change his behaviors. -Resident 1 got physically close to residents. Residents were afraid of him. -Resident 1 threatened and intimidated people. -Staff had attempted redirection, positive reinforcement when resident 1's behaviors had escalated. -Residents had been told if they felt uncomfortable with resident 1 to report that to staff. Interview on 8/6/13 at 3:30 p.m. with case manager C revealed: *He was a case specialist with Southeastern Behavioral HealthCare (SEBH). *Had been assigned to resident 1's case due to resident 1 not liking case specialist A. *The day of the alleged incident beween residents 1 and 2 revealed: -He had stopped by the facility between 3:30 p.m. and 4:00 p.m. He liked to do surprise visits at the facility. -Staff pulled him into the case specialist's office and informed him resident 1 had been making out with another female resident. -Police had been called. -He sat and waited for the DON and the CEO to arrive. -He suggested resident 1 go to a motel that night, since no staff wanted him at the facility. -The DON, CEO, administrator, and him had discussed the idea of resident 1 going to a motel.	S 838		

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S 838	Continued From Page 46 -He had helped resident 1 pack up his bags. -All the medications were given to him including all the diabetes meds, needles, and the facility glucometer. There was "enough for a week." -The facility gave resident 1 some type of print out. -He took resident 1 to the motel, got him checked in, oriented him to the place, and then told him to call him the next day. -Resident 1 had forty dollars in cash. -Confirmed resident 1 had his insulin before leaving the facility but was going to go to the restaraunt next door and eat. Resident 1 had not eaten prior to that time. -He last saw resident 1 at 7:00 p.m. when resident 1 told him to go. -He only worked 8:00 am to 5:00 pm, but resident 1 "got two extra hours of his time." -He could not remember how he had found out about resident 1 being hospitalized. But he had been informed resident 1 had been found unresponsive in a downtown alley and then taken to Sanford ICU. -He saw resident 1 multiple times each week. -Resident 1 would get alcohol, not food, and would be found passed out. -Resident 1 was a preteen in an adult body. -In the past he had taken other people to motels or usually to the missions, but resident 1 had been kicked out of there. -He considered resident 1 responsible to take his own meds and eat correctly. -He did not feel he was responsible to make sure resident 1 took his meds. -Resident 1 had been kicked out of SEBH IMPACT program due to refusal to follow protocol to take medications. -Resident 1 had gone to a nursing home and was kicked out, next week he had gone to HSC, then to Cayman Court, and then to HSC. HSC did not want to deal with him, so he was	S 838		

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S 838	Continued From Page 47 discharged homeless and went to the mission. HSC said SEBH was responsible for resident 1 since he was in the system and "they could deal with him." -He "stepped up" to help resident 1 through two different housing facilities, pay by the month hotel but was kicked out due to making sexual advances toward women. -Resident 1 had a long history of sexual inappropriateness and had been kicked out of the mission due to that behavior. *Following all of that he had sat down with the CEO, DON, and case manager to discuss admitting resident 1 to Cayman Court. *Regarding the alleged incident between resident 1 and 2 he did not feel the police should have been called. There was "No malice behind it." Telephone interview on 8/6/13 at 5:30 p.m. with former employee resident assistant (RA)B revealed: *The day of the alleged incident between resident 1 and 2 revealed: -The facility had just gotten in a new resident (resident 1) about a month ago. -He had been causing issues such as harrassing the other residents and staff, tried to bully others into giving him things, scared the residents, wanted cigarettes, and made inappropriate sexual comments towards female residents and female staff. -Resident 1 left every day going out into the community. -The police had told him they wanted a meeting with the CEO to inform her "they felt resident 1 was a risk towards other residents and it was just a matter of time before he did something violent/inappropriate." *On the day of the alleged incident the administrator and another RA had told him to come to the laundry area. They were upset and	S 838		

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told him what they had seen. They had seperated the two residents. He monitored resident 1 after the alleged incident.
-He stayed with resident 1 until the police came.
-As officers were talking with the administrator, the RA, and resident's 1 and 2 the CEO was "trying to get words in edge wise." The DON then showed up at the facility.
-The CEO and DON were "playing it off as two consenting adults kissing."
-The CEO had told him the DON had told the police that resident 1 had the mental capacity of an 11 to 13 year old.
-After police were done with the investigation, the police had decided they were "not capable to assess if indeed a sexual assault had taken place."
-The DON had left by that time.
-The CEO had told him that all Cayman Court staff did not know how to perform their jobs, and that was why the alleged incident had occurred.
-He was not part of resident 1 being discharged.

Interview on 8/7/13 at 8:40 a.m. with maintenance man E revealed:
*On 6/14/13 somewhere around 8:30 a.m. resident assistant (RA) F had come and got him to go to resident 8's room. Then:
-He knocked on resident 8's door.
-Resident 8 had lost her key to her room, so the door was unlocked.
-As he stood in the doorway he saw resident 1 standing beside her dresser where he could not be seen.
-Resident 8 was asleep on her bed.
-He had asked resident 8 who was then awakened if she had invited someone into her room.
-Resident 1 then approached the end of resident 8's bed, crossed his arms, and stood staring at her.

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-He then told resident 1 to leave her room which he did.
-All that morning resident 1 was pacing the halls trying to get in other residents' rooms.

Interview on 8/7/13 at 8:50 a.m. with RA F revealed:
*On 6/14/13 around 9:00 a.m. she had noticed resident 1 was down a hallway at different doorways asking residents for pop, cigarettes, and money. Then:
-She saw resident 1 standing by resident 8's doorway. He had walked into resident 8's room.
-She then went and got maintenance man E, and they both went to resident 8's room.
-Resident 1 was standing at the end of resident 8's bed with his arms crossed watching her sleep.
-Maintenance man E instructed resident 1 to leave the room.

Interview on 8/7/13 at 9:10 a.m. with maintenance man E revealed:
*Staff were afraid of resident 1.
*Resident 1 would swear at female staff.
*Staff would come and get him when they needed to interact with resident 1.

Interview on 8/7/13 at 9:46 a.m. with the director of nursing (DON) revealed:
*The day of the alleged incident on 6/19/13 between resident 1 and 2:
-She had received a text message from the administrator requesting her to come to the facility regarding the alleged incident.
-She had called the CEO about the alleged incident.
-A police officer had asked about resident 1's cognitive level, and she said it was that of a teenager. She then left the med room.
-She then asked if she could leave and was told

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S 838	Continued From Page 50 she could. -She had left the facility before resident 1 and case manager C had left. *She confirmed she was not aware of resident 1's MMSE score of 30/30. *They had a meeting before resident 1 had returned to the facility. She was not sure if there was any documentation of that meeting. The individuals at the meeting included the CEO, the clinical director of SEBH, case specialist A, and the development director of SEBH. *The evening of the alleged incident her expectations would have been: -For a better discharge process. -The MAR and TAR should have been sent with resident 1. -There should have been more physician involvement. -Resident 1 had an increase in behaviors, and the physician should have been made aware of that. -There was not a physician's order to discharge resident 1. -Resident 2 had a diagnosis of mild mental retardation, had scored 20/30 on the MMSE, and did not believe she could consent to any type of sexual involvement. -She would have considered resident 2 cognitively impaired (confused). -She was not aware of how optional services for cognitively impaired was obtained for an assisted living license. -She was unaware of the incident that had occurred on 6/14/13 with resident 1 and 8, and resident 8 had lost her keys. She did confirm resident 8 had keys now for her room. -Did not know how to answer the question regarding what did the facility do to protect the residents from resident 1. -Did agree all the residents were vulnerable adults.	S 838		

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S 838	Continued From Page 51 -It was not uncommon for resident 1 to be out on his own with his meds. -"Took him back after he had been commited to HSC because there was no where else for him to go." Review of the provider's revised June 2011 Director of Nursing job description revealed: *Job summary: "Supervise and coordinate the nursing, medical services of Southeastern facilities. Provide nursing/medical consultation, education, and support to Southeastern staff as needed." *"Coordinate the ongoing education of consumers concerning medication, self administration of medication, and medical/health issues." *"Keep MAR current to changes in meds." *"Oversee the documentation of medication management and assess need for system change/further training, etc." *"Coordinate closely with staff psychiatrist and psychiatric residents to maximize psychiatric care/coverage of consumers." *"Participate in the ongoing quality assurance review system in order to: -Provide effective feedback to staff and program. -Ensure continuous quality improvement in service provision." *"Provide emergency on-call coverage in rotation with other SBH nursing staff when necessary." Interview on 8/7/13 at 10:45 a.m. with case specialist A revealed: *She had not come to the facility the day of the alleged incident on 6/19/13 between resident 1 and 2. *She was unaware of resident 1's sexual inappropriateness until after he had been at the facility for several weeks. She had received	S 838		

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S 838	Continued From Page 52 emails from case manager C in regards to the above. *The administrator had made the decision to admit resident 1 to the facility. *She had gone to HSC and had done a pre-admission assessment, and the records had indicated resident 1 had improved. *She felt if she had known about resident 1's sexual inappropriateness they would have declined admission for him. *Confirmed the administrator should have contacted physician's during resident 1's increase in behaviors. *Meetings were held, and they had been informed to redirect, and reward good behavior. Confirmed there was no documentation related to that. *The administrator had spoken with the CEO regarding her concerns about resident 1. The administrator had informed her the CEO said we "Need to keep the resident safe. We need to respect his humaness, redirect, watch him, don't let him leave, have him color pictures." *She did not feel having resident 1 color pictures was appropriate and was demeaning. *Confirmed: -That incident reports and investigations for residents 1 and 2 should have been done. -She was not aware any incidents had ever been reported to the South Dakota Department of Health (SD DOH). -There should have been more documentation regarding residents 1, 2, and 8. Review of the provider's undated CARE Specialist job description revealed: *Job functions: -"Client's rights should be ensured. -Provide direct assistance to ensure that clients obtain the basic necessities of daily life and are able to perform basic daily living activities. This	S 838		

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S 838	Continued From Page 53 assistance includes, but not limited to - advocacy and representation. -Coordinate with hospital psychiatrist, social workers and nursing staff for discharge planning. -Provides crisis intervention services for the severely mentally ill client. -Provide linkage between CSS and psychiatric services. -Develop individual treatment/case service plan for each client and reevaluate and update every six months. -Maintain accurate progress notes and case records on all therapeutic contacts. -Write necessary reports and prepare documents for other agencies as needed. -Accurately document client's symptoms, response to treatment and medication side effects. -Attend and participate in supervision, consultation, in-service training, staff meeting, workshops and related committees as assigned." Interview on 8/7/13 at 1:45 p.m. with the chief executive officer (CEO) revealed: *The day of the alleged incident on 6/19/13 between residents 1 and 2: -She had received a phone call from the DON informing her a sexual assault had taken place, and the police had been called. -She came to the facility immediately. -She met with the police. -Police said nothing could be done to arrest resident 1 since no criminal activity had taken place due to the resident's age. -Resident 2 did not want to file a complaint. -There were no grounds for police to arrest and remove resident 1. -The police told resident 1 he had to stay in his room. -The administrator, case manager C, and she did not feel it was appropriate to leave resident 1 in	S 838		

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S 838	Continued From Page 54 the facility. -Case manager C got a motel room for resident 1. -Residents 1 and 2 had the same mental function level. -Did not know if resident 2 was capable of making decision for sexual interaction with resident 1. -Did not feel resident 2 had been sexually assualted. -Was unaware resident 1 had a 10th grade high school level, and that he had scored 30/30 on the MMSE. -Was unaware resident 2 had a diagnosis of mild mental retardation and had scored 20/30 on the MMSE. -The administrator had not informed her of the above. -Confirmed cognitively impaired was not on the facility's current assisted living license. *Confirmed: -She had not assigned anyone to monitor resident 1 at the motel. -She had tried to put resident 1 somewhere safe. -Resident 1 when on his own, knew he needed to take his meds. -Her hope was resident 1 would have been arrested. *Did not answer the question related to should resident 1 have been discharged with the MAR and TAR. *Confirmed she was at the facility when case manager C had left with resident 1. *Confirmed resident 1 "fell through the cracks." *The reason resident 1 had been taken back at the facility after the IVC (involuntary commital) was they had decided to do one more trial run. *She had met with the administrator and case specialist A who had said they could handle him. -Both said "No problem, We can handle him. Staff sabataged his stay."	S 838		

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S 838	Continued From Page 55 -Resident 1 had diabetes "bad." -Cayman Court was built for the mentally ill and the homeless. *Resident 1: -Was on the extreme side of being mentally ill. -Needed more watching. -Was developementally delayed and had the behárioral age of seven. -Required a lot of redirections. -Did things as a child who required a lot of redirection. *Had asked the administrator if the staff needed additional training, because she did not want the staff sabbatoging resident 1's stay. *Had met with the administrator and the case specialist on 6/18/13 to discuss what to do for activities for resident 1. Activities included to redirect him, let him draw. *Was unaware that certain types of incidents were required to be reported to the SD DOH. *Confirmed there was a Quality Assurance Committee for SEBH but not sure if the facility had one. *Did not agree care plans were only done per resident agreement. Review of the Sioux Falls Police Department summary regarding the alleged incident between residents 1 and 2 on 6/19/13 revealed: *At approximately 1543 (3:43 p.m.) hours on June 19, 2013 officer was dispatched to Cayman Court for a duress alarm. *While en route Metro Communications advised there was possibly an assault that had occurred. *On arrival the officer spoke with the administrator regarding an incident that had happened in the laundry room by another resident, and that was why the duress alarm had been pushed. *The officer spoke with resident 2 who stated she was in the laundry room when resident 1 came	S 838		

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in. "He started to kiss her on the lips and told her that he loved her and that he had no other girlfriends. He then lifted up her shirt and bra and put his hand on her left breast. She said that the two never had any sexual contact before and she told him "no" several times. Resident 1 left then came back and told her the same things but didn't touch her, that is when the staff came."
*The officer was "advised by staff that resident 2's brain function is that of a 5-6 year old and resident 1's is that of a 5-13 year old."
*The officer spoke with resident 1 who told him "that the two were consensually kissing and that was that."
*A supervisor was contacted about the incident. The decision was made to document the incident with a case report and residents 1 and 2 were left at the facility. The officer had attempted to make contact with resident 2's mother/guardian but had been unsuccessful.

Review of the provider's revised 1/21/08 Violent Situation policy revealed staff shall complete an incident report.

Review of the provider's 1/24/13 Abuse and Neglect policy revealed:
*Sexual Abuse: "Any non-consenting sexual act or behavior or consenting act if age 16 or older and/or unable to make informed consent. Forcing sexual activity by the use of intimidation and/or the threat of further violence if one's advances are refused."
*Sexual Contact: "Any touching, not amounting to rape, of the breast of a female, or the genitalia or anus of any person with the intent to arouse or gratify the sexual desire of either party. (By legal precedent this includes contact through clothing.)"

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