STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435112	A. BUILDING _____ B. WING _____	C 06/26/2025

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OAKVIEW TERRACE	510 E 8TH ST FREEMAN, SD 57029

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/24/25 through 6/26/25. Oakview Terrace was found not in compliance with the following requirements: F640, F641, F655, F732, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/24/25 through 6/26/25. Areas surveyed included resident safety related to a resident who fell and was evaluated at the emergency room, and a resident who was left in the bathtub unattended, certified nursing assistant (CNA) qualification and staffing, facility cleanliness, and proper food handling by staff. Oakview Terrace was not in compliance with the following requirement: F689.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640	The facility will ensure that MDS/RN C and/or designee will complete all residents' death tracking record assessments no later than seven days after a resident's death in the facility. Resident 12's Death Record could not be completed in 7 days due to the timeframe being in the past. However, on 6/25/25, MDS/RN C completed and transmitted to CMS resident 12's MDS death in facility tracking record assessment. Assistant Administrator confirmed submission to and acceptance from CMS of resident 12's death tracking record assessment on 7/11/2025. On 7/14/2025, Administrator & Assistant Administrator reviewed the "LTC Resident-Assessment-Instrument (RAI)-System Standard Policy" noting that the policy states "Tracking Records – Must be completed for any resident residing in a Medicare or	8/7/2025

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

CEO/Administrator | 7/17/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 640	Continued From page 1 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure a Minimum Data Set (MDS) discharge tracking record assessment was completed within the required timeframe for one of one sampled resident (12)	F 640	Medicaid certified facility regardless of payment source…Death in Facility within 7 [seven] days after the resident's death" and "The Assessment Coordinator is responsible for electronically transmitting encoded, accurate and complete MDS data." On 7/15/25, Assistant Administrator reviewed and educated MDS/RN C and DON B on FRHS LTC Resident-Assessment-Instrument (RAI)-System Standard Policy. Beginning on 7/16/25, Assistant Administrator and/or designee will perform on all deceased residents "MDS Death Tracking Record Assessment audits" weekly for 8 weeks to ensure that all death tracking record assessments are completed no later than seven days after a resident's death in the facility. Assistant Administrator and/or designee will report the result of the audits to QAPI committee weekly. The QAPI committee will direct further audits. Beginning on 7/16, Assistant Administrator and/or designee will perform "CMS Resident Census audit" monthly for 3 months to ensure that all death tracking record assessments are submitted to CMS accurately and timely. Assistant Administrator and/or designee will report the result of the audits to QAPI committee monthly. The QAPI committee will direct further audits.	

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F 640	Continued From page 2	F 640		

after her death in the facility.
Findings include:

1. Review of resident 12's electronic medical record (EMR) revealed:
*She died in the facility on 5/2/25.
*A significant change MDS had been completed on 2/11/25.
*A quarterly MDS had been completed on 12/2/24.
*No MDS tracking record had been completed when resident 12 died.

2. Interview on 6/25/25 at 2:14 p.m. with MDS/ registered nurse (RN) C revealed she:
*Was responsible for completing and transmitting the MDS data for all residents.
*Expected that resident 12 would have had an MDS tracking record assessment completed when she died, and confirmed that one had not been completed.
*Tracked the MDS assessments that would need to have been completed by utilizing the dashboard alerts in the PointClickCare EMR system.
*Stated it had been an oversight that resident 12's death in the facility tracking MDS had been missed.

3. Interview on 6/26/25 at 12:39 p.m. with director of nursing B revealed she expected "one hundred percent" compliance with the timely completion and submission of MDS data.

4. Review of the Resident Assessment Instrument (RAI) manual revealed that the death in facility tracking record assessment was to have been completed no later than seven days after a resident's death in the facility.

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F 640	Continued From page 3 Review of the provider's June 2025 LTC (Long Term Care) Resident-Assessment-Instrument (RAI)- System policy revealed: *"The Assessment Coordinator is responsible for ensuring the Interdisciplinary Team (IDT) complete timely assessments and reviews in accordance with the CMS RAI Version 3.0 Manual." *"Tracking Records - Must be completed for any resident in a Medicare or Medicaid certified facility regardless of payment source: ... Death in Facility : Within 7 [seven] days after the resident's death." *"The Assessment Coordinator is responsible for electronically transmitting encoded, accurate and complete MDS data ..." Review of the Centers for Medicare and Medicaid Services' October 2023 Version 1.18.1 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual revealed death in facility tracking records: *"Must be completed when the resident dies in the facility or when on LOA [leave of absence]." *"Must be completed within 7 days after the resident's death..."	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification.	F 641	Facility will ensure that MDS/RN C and/or designee will accurately code resident 7's and all residents' injectable diabetic medications on the Minimum Data Set (MDS) assessment. On 7/15/25, MDS/RN C completed a Modification of Quarterly assessment MDS for Resident 7's 4/1/25 MDS and transmitted the modified assessment to CMS on 7/15/2025. Assistant Administrator confirmed submission to and acceptance from CMS of this modification assessment on 7/16/2025. On 7/15/25, MDS/RN C completed a Modification of Quarterly assessment MDS	8/7/2025

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F 641	Continued From page 4 §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the provider failed to ensure one of one resident (7) who received an injectable diabetic medication had that medication coded accurately on the Minimum Data Set (MDS) assessment. 1. Interview on 6/24/25 at 2:45 p.m. with resident 7 revealed: *She had diabetes (a group of diseases that result in too much sugar in the blood). *She received an injectable medication weekly to treat her diabetes. *Her blood sugars were monitored by staff. 2. Review of resident 7's electronic medical record (EMR) revealed: *She was admitted on 12/27/23. *She had a Brief Interview for Mental Status	F 641	for Resident 7's 4/1/25 MDS and transmitted the modified assessment to CMS on 7/15/2025. Assistant Administrator confirmed submission to and acceptance from CMS of this modification assessment on 7/16/2025. On 7/14/2025, Administrator & Assistant Administrator] reviewed the FRHS LTC Resident-Assessment-Instrument (RAI)-System Standard Policy noting that the policy states that the facility: "will ensure 'the Resident Assessment Instrument (RAI) is used, in accordance with specific format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified. The quarterly reviews assessment is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored." On 7/15/25, Assistant Administrator reviewed and educated MDS/RN C & DON B on FRHS LTC Resident-Assessment-Instrument (RAI)-System Standard Policy" and that dulaglutide is not a form of insulin and that accurate documentation of medication administration is required on all MDS assessments. No other licensed nurses perform MDS assessments. Beginning on 7/16/2025, Assistant Administrator will perform MDS Accuracy audits weekly for 16 weeks to ensure accurate coding of injectable diabetic medications. Audits will include Resident 7. Assistant Administrator will report the result of the audits to QAPI committee weekly. The QAPI committee will direct further audits.	

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F 641	Continued From page 5	F 641		

(BIMS) assessment score of 15, which indicated she was cognitively intact.
*She had a diagnosis of diabetes.
*Her blood sugars were monitored weekly by staff.
*A 1/19/25 physician's order for "Dulaglutide Subcutaneous Solution Auto-Injector Inject 0.5 ml [milliliters] subcutaneously one time a day every Sun". That order was discontinued on 3/23/25.
*A 3/23/25 physician's order for, "Dulaglutide Subcutaneous Solution Auto-Injector [an injectable medication to treat diabetes] Inject 0.75 ml [milliliters] subcutaneously one time a day every Sun [Sunday]".
*Item N0350A of section N "Medications" of her 4/1/25 quarterly MDS (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment indicated she had received insulin injections seven times during the seven-day look-back period (the time period over which the resident's condition or status is captured by the MDS assessment) of that MDS.
-Dulaglutide's medication classification was glucagon-like peptide-1 (GLP-1) agonists, which was not a form of insulin. It was administered weekly on Sundays, not daily.

3. Record review and interview on 6/26/25 at 8:51 a.m. with registered nurse (RN) I regarding resident 7 revealed:
*The resident had a physician's order for dulaglutide to treat her diabetes, which was to be administered weekly on Sundays.
*RN I verified that dulaglutide was not a form of insulin.
*There were no current physician orders for insulin for resident 7.

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F 641	Continued From page 6	F 641		

4. Interview and record review on 6/26/25 at 12:05 p.m. with MDS/RN C revealed:
*She had completed resident 7's most recent MDS assessment on 4/1/25.
*She verified she had documented in that MDS that resident 7 had received an insulin injection seven times during the seven-day look-back period.
*MDS/RN C stated she thought dulaglutide was a form of insulin.
*MDS/RN C verified resident 7 had received one injection of dulaglutide in the seven-day look-back period.
*She thought she entered dulaglutide as an insulin on the MDS because it was documented under the insulin administration tab in the medication administration record (MAR). She was unsure why she documented that resident 7 had received seven injections during that seven-day look-back period.
*She agreed she had made an error in the resident's MDS assessment documentation.

5. Interview on 6/26/25 at 12:09 p.m. with director nursing (DON) B revealed:
*She confirmed resident 7 was on dulaglutide injections weekly and had not been on insulin during the look-back period of her 4/1/25 MDS assessment.
*She verified the above error in the documentation within resident 7's 4/1/25 quarterly MDS assessment.
*She expected the MDS assessment documentation to be completely accurate upon submission.

Review of the Centers for Medicare and Medicaid Services' October 2023 Version 1.18.1 Long-Term Care Facility Resident Assessment

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F 641	Continued From page 7 Instrument (RAI) 3.0 User's Manual regarding insulin documentation in section N revealed: *"Review the resident's medication administration records for the 7-day look-back period." *"Determine if the resident received insulin injections during the look-back period." *"Enter in Item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received." Review of the provider's 1/15/25 LTC [long-term care] Resident-Assessment-Instrument (RAI)-System Standard policy revealed: *"[Provider name] will ensure 'the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strength and needs, as well as offering guidance for further assessment once problems have been identified.'" *The quarterly review assessment "is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored."	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident	F 655	Facility will ensure that all new residents will have a completed baseline care plan within 48 hours of admission and all new residents or their representative will be provided a written summary of the baseline care plan within 48 hours of admission to the facility. On 7/14/2025, Administrator & Assistant Administrator reviewed the FRHS Baseline Care Plan policy noting that the policy states:	8/7/2025

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F 655	Continued From page 8 that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 655	• "A baseline care plan will be developed within 48 hours of a resident's admission to promote continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable are informed of the initial plan of delivery of care and services by receiving a written summary of the baseline care plan. •The baseline care plan will include the minimum health care information necessary to properly care for a resident including, but not limited to: • Initial goals based on admission orders, • physician orders, • dietary orders, • therapy services, • Social services, • PASRR [Pre-Admission Screening and Resident Review] recommendations, if applicable, • Instructions needed to provide effective person-centered care that meets professional standards of quality of care, • Address resident safety concerns to prevent decline or injury, • Identify needs for supervision, behavioral interventions and assistance with ADL's [activities of daily living] as necessary. • There will be documentation in the clinical record that the baseline care plan was given to the resident and/or representative." On 7/15/2025, Assistant Administrator reviewed and educated Director of social services F, and Director of Nursing B on the FRHS Baseline Care Plan policy.	

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F 655	Continued From page 9 Based on record review, interview, and policy review, the provider failed to complete a baseline care plan and provide a written summary of the baseline care plan to the resident or their representative for seven of seven recently admitted sampled residents (11, 14, 17, 37, 38, 40 and 195) within 48 hours of their admission to the facility. Findings include: 1. Review of resident 11's electronic medical record (EMR) revealed: *She was admitted on 11/18/24. *Her baseline care plan revealed her preferred wake time had been left blank. *There was no documentation that indicated the resident's baseline care plan was developed and reviewed with her, her representative, or that they had been provided or offered a copy of her baseline care plan within 48 hours of her admission. 2. Review of resident 37's EMR revealed: *He was admitted on 10/22/24. *His baseline care plan did not include his dietary orders. His preferred wake time, sleep time, and bathing preferences had been left blank. *There was no documentation that indicated the resident's baseline care plan was developed and reviewed with her, her representative, or that they had been provided or offered a copy of her baseline care plan within 48 hours of her admission. 3. Review of resident 38's EMR revealed: *She was admitted on 12/3/24. *Her baseline care plan did not include initial goals or a discharge plan, and her preferred wake time had been left blank.	F 655	On 7/17/2025, Assistant Administrator reviewed and educated RN H on the FRHS Baseline Care Plan policy. By 7/22/2025, all licensed nurses and social services employess will receive education on the Baseline Care Plan Policy and attestation of completion and understanding is to be completed by 8/7/2025. All employees on prn or on leave of absence status will complete this education prior to their return to work. Beginning on 7/16/2025, Director of Social Services and/or designee will perform “Baseline Care Plan Completion” audits for all residents admitted to the facility weekly for 8 weeks to confirm that Baseline Care Plans are completed within 48 hours and residents or their representatives were provided a written summary of the baseline care plan within 48 hours of admission to the facility. Assistant Administrator will report the result of the audits to QAPI committee weekly. The QAPI committee will direct further audits.	

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F 655	Continued From page 10	F 655		

*There was no documentation that indicated the resident's baseline care plan was developed and reviewed with her, her representative, or that they had been provided or offered a copy of her baseline care plan within 48 hours of her admission.

4. Review of resident 40's EMR revealed:
*She was admitted on 2/13/25.
*Her baseline care plan did not include initial goals or a discharge plan, and her preferred wake and sleep times had been left blank.
*There was no documentation that indicated the resident's baseline care plan was developed and reviewed with her, her POA, or that they had been provided or offered a copy of her baseline care plan within 48 hours of her admission.

5. Review of resident 14's EMR revealed:
*She was admitted on 6/5/25.
*Her baseline care plan did not include the date when the baseline care plan was completed, or by whom.
*There was no documentation that indicated the resident's baseline care plan was developed with her, her representative, or that they had been provided or offered a copy of her baseline care plan within 48 hours of her admission.

6. Review of resident 17's EMR revealed:
*She was admitted on 6/11/25.
*Her baseline care plan did not include her preferred wake time, sleep time preference, her bathing preference, her discharge goal, the date when the baseline care plan was completed, or by whom.
*There was no documentation that indicated the resident's baseline care plan was developed with her, her representative, or that they had been

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provided or offered a copy of her baseline care plan within 48 hours of her admission.

7. Review of resident 195's EMR revealed:
*She was admitted on 6/12/25.
*Her baseline care plan did not include the date when the baseline care plan was completed, or by whom.
*There was no documentation that indicated the resident's baseline care plan was developed with her, her representative, or that they had been provided or offered a copy of her baseline care plan within 48 hours of her admission.

8. Interview on 6/25/25 at 2:31 p.m. with director of social services F regarding residents' baseline care plans revealed:
*Nursing staff was responsible for completing the residents' baseline care plans when they admitted to the facility.
*She expected that all areas within the baseline care plan to be completed.
*It was not the provider's process to document when the resident's baseline care plan would have been completed or by whom.
*It was not the provider's process to document on the resident's baseline care plan or in the resident's EMR if or when the baseline care plan was reviewed and offered to the resident or the resident's representative.
*If the resident representative was not present to be able to review the resident's baseline care plan, the social services department would mail a copy of the baseline care plan to the resident's representative.
*She had not documented when she mailed the resident's baseline care plan, or to whom.
*She agreed that if she mailed the resident's baseline care plan to the resident's

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representative, it would not have been available for review within the first 48 hours of the resident's admission.

9. Interview on 6/25/25 at 2:31 p.m. with registered nurse (RN) H regarding residents' baseline care plans revealed:
*The nurse was to complete the baseline care plans upon the resident's admission.
*She stated the baseline care plans were usually completed within the first few hours of a resident's admission to provide direction for the resident's care needs and preferences, but the baseline care plan must be completed within 48 hours of their admission.
*All areas of the baseline care plan were expected to be completed.
*She did not review the baseline care plan with the resident or the resident's representative once it was completed.
*She did not provide or offer a copy of the baseline care plan to the resident or the resident representative upon completion.
*She verified there was no location on the baseline care plan to document when it was completed or by whom.
*She did not document in the EMR when the resident's baseline care plan had been completed.

10. Interview on 6/26/25 12:09 p.m. with director of nursing (DON) B regarding baseline care plans revealed:
*She expected all areas of the baseline care plan to be completed within 48 hours of a resident's admission.
*She agreed without documentation of the date the baseline care plan was completed, there was no way to verify if it was completed within 48

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F 655	Continued From page 13 hours of the resident's admission. *She was aware there was no documentation to support that the resident's baseline care plans were reviewed or if a copy was offered to the resident or the resident's representative. Review of the provider's June 2025 Baseline Care Plan policy revealed: *"A baseline care plan will be developed within 48 hours of a resident's admission to promote continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable are informed of the initial plan of delivery of care and services by receiving a written summary of the baseline care plan." *"The baseline care plan will include the minimum health care information necessary to properly care for a resident including, but not limited to: 1. Initial goals based on admission orders, 2. physician orders, 3. dietary orders, therapy services, 5. Social services, 6. PASRR [Pre-Admission Screening and Resident Review] recommendations, if applicable, 7. Instructions needed to provide effective person-centered care that meets professional standards of quality of care, 8. Address resident safety concerns to prevent decline or injury, 9. Identify needs for supervision, behavioral interventions and assistance with ADL's [activities of daily living] as necessary." *"There will be documentation in the clinical record that the baseline care plan was given to the resident and/or representative."	F 655		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689	The facility will ensure that CNA K, CNA S (CNA Q is no longer employed at the facility)	8/7/2025

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F 689	Continued From page 14 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, observation, record review, interview, and policy review, the provider failed to follow resident's care plans to: *Provide adequate supervision for one of one sampled resident (40) who was left unsupervised in the whirlpool tub by two certified nursing assistants (CNA) (K and Q). *Provide adequate assistance by one of one CNA (S) for one of one sampled resident (38) who fell and sustained an injury and pain that required evaluation at the emergency room. Findings Include: 1. Review of the provider's 4/29/25 SD DOH FRI revealed: *On 4/28/25 at 4:15 p.m., CNAs O and P "heard [resident 40] yell Hello from the [whirlpool] tub room," and "went into [the whirlpool] tub room and noted [resident 40] sitting in the whirlpool [tub] without any staff member present." *CNA O immediately assisted resident 40 out of the [whirlpool] tub and back to her room. *The provider's investigation revealed that CNA K had initiated resident 40's bath and then had asked CNA Q to finish providing that bath. CNA Q then "requested Charge Nurse [registered nurse	F 689	and all other direct care employees will follow resident 40's, resident 38's, and all other residents' care plans to provide adequate supervision in the whirlpool tub and adequate level of assistance. On 7/14/2025, Administrator and Assistant Administrator reviewed the Bathing policy, including: • "Ensure the resident's safety during bathing. Resident needs to sit on bath/ shower chair. Fasten bath/shower chair belt. • Visit with the resident during bathing and keep conversation focused on his/her interests… • Do not leave the resident alone in the shower/tub room. Use the call light if you need assistance." On 7/14/2025, Administrator and Assistant Administrator reviewed the LTC Falls and Accidents policy including: • "Supervision/adequate supervision: This determination is based on the individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident, • All staff will be educated about and have access to care plans which are individualized for each resident… • Based on assessment of fall risk ..., staff will implement appropriate individualized, resident-centered interventions to reduce the likelihood of falls ... and communicate the risk and interventions to the staff through the plan of care." On 7/15/2025, Administrator and Assistant Administrator reviewed Resident 40's Care Plan which was updated to indicate	

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F 689	Continued From page 15 (RN) R] tell CNA P to go into the [whirlpool] tub room to sit with [resident 40]." *CNA Q "kept moving assuming she [RN R] had passed on that message [to CNA P]." *"CNA O indicated she knew [CNA K] gave [resident 40] a bath and that [CNA K's] scheduled shift ended at 3:30 p.m." *When interviewed regarding that bath, resident 40 indicated, "It was wonderful! I soaked and I enjoyed it!" *When asked if she had to "wait long after she called out," resident 40 stated, "No, what [when] I was ready, I yelled Hello and a nice young lady came [in] right away." *" ...Poor communication and multiple assumptions amongst multiple staff impacted this situation." *"CNA Q was the last staff member in the [whirlpool] tub room with [resident 40] and should not have left [resident 40] alone in the [whirlpool] tub room ..." 2. Interview on 6/24/25 3:40 p.m. with resident 40 and her power of attorney (POA) revealed: *Resident 40 recalled the above event when she was left alone in the whirlpool tub and stated, "I loved it." *She indicated that she had been wearing a "plastic safety strap" and had not been worried or afraid when she was left alone. She had requested to soak in the whirlpool tub, and the staff had come into the room right away when she called out. *She knew CNA K had to leave that day while she was in the whirlpool tub, and that there had been a miscommunication between the staff about who was going to help her in getting out of the whirlpool tub. *She got herself washed and dressed each day,	F 689	"BATHING/SHOWERING: [Resident 40] needs 1 assistance (SBA) to get in and out of whirlpool tub. Staff needs to remain in whirlpool room while [Resident 40] is in whirlpool tub, [Resident 40] is able to bath self independently once is the whirlpool tub." On 7/14/2025, Administrator and Assistant Administrator reviewed Resident 38's Care Plan and no changes were made. On 7/15/2025, Administrator reviewed and educated CNA S on the LTC Falls and Accidents policy as well as how to access Care Plans in the EMR, location of individualized resident-centered fall interventions on the Care Plan and the need to remain within arm's reach of a resident who has a standby assist level of assistance. On 7/16/2025, Assistant Administrator reviewed and provided education to CNA K on the FRHS Bathing Policy & Procedure and provided education that nursing staff who start a bath are to complete the bath. By 7/22/205, all direct care staff, including CNA S & CNA K (CNA Q no longer works at this facility), will receive education including the Bathing Policy and Procedure, the LTC Falls & Accidents Policy and Procedure, how to access Care Plan in EMR, where to access individualized resident-centered fall interventions on the Care Plan, the need to remain within arm's reach of a resident who has a standby assist level of assistance, and that nursing staff who start a bath are to complete the bath. Education and attestation of completion and understanding is to be completed by 8/7/2025. All employees on prn or on leave of absence status will complete this education prior to their return to work.	

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F 689	Continued From page 16 but was told after the incident on 4/28/25 that someone was supposed to have remained in the whirlpool tub room with her that day. *She had not been left alone in the whirlpool tub before the incident on 4/28/25 or since then. *She stated that she did not want anyone to get in trouble, she loved it there, and that the staff were "my little angels." *Her POA stated that she had been informed of the incident, she had no concerns, and that resident 40 had shared with her "it was the best bath." 3. Review of resident 40's electronic medical record (EMR) revealed: *She was admitted on 2/13/25. *Her 2/20/25 Brief Interview of Mental Status (BIMS) assessment score was 9, which indicated she was moderately cognitively impaired. *Her 5/20/25 BIMS assessment score was 11, which indicated she was moderately cognitively impaired. *Her 2/26/25 revised care plan indicated she preferred a shower and required one staff member's assistance to get in and out of the shower, to wash her lower body, back, and hair. *Her 4/28/25 revised care plan indicated she preferred a shower and required one staff member's assistance "to get in and out of the whirlpool tub," and to wash her lower body, back, and hair. *Her 5/28/25 revised care plan indicated she preferred a shower and required one staff member's "assistance (SBA) [stand by assistance] to get in and out of the whirlpool tub. Once in the whirlpool [tub] [resident 40] is independent with bathing, staff [member] to stay in [the] room and assist as needed and requested by [resident 40]."	F 689	Beginning on 7/21/2025, Director of Nursing or designee will perform 3 Bathing Supervision audits weekly for 8 weeks to ensure residents are supervised during the entire bath and that the same employee that started a bath completed it. Audits will include Resident 40. Assistant Administrator will report the result of the audits to QAPI Committee weekly. The QAPI committee will direct further audits. Beginning on 7/21/2025, Director of Nursing or designee will perform 3 Level of Assistance Observational audits weekly for 8 weeks to ensure residents are receiving adequate level of assistance per their care plan. Audits will include Resident 38. Assistant Administrator will report the result of the audits to QAPI committee weekly. The QAPI committee will direct further audits.	

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4. Observation on 6/25/25 at 9:00 a.m. of the nurses' station and whirlpool tub room revealed:
*The whirlpool tub room was located directly across from the nurses' station.
*While standing at the furthest point away from that whirlpool tub room, at the nurses' station, the conversation between the staff and the resident in that whirlpool tub room was able to be heard over the noise of the whirlpool jets.

5. Interview on 6/26/25 at 7:45 a.m. with director of nursing (DON) B revealed that CNA Q had resigned and was not available for an interview related to the 4/28/25 incident with resident 40.

6. Interview on 6/26/25 at 10:13 a.m. with CNA K revealed:
*On 4/28/25, she had been asked by CNA Q to provide resident 40 with a whirlpool bath. She had started that whirlpool bath; however, her shift ended at 3:30 p.m., and she needed to leave.
*CNA K requested that CNA Q finish resident 40's whirlpool bath, and CNA K provided CNA Q with a verbal report in the whirlpool room of what tasks needed to be finished, and that resident 40 had requested to soak in the tub.
*CNA K knew that resident 40 liked to take a long bath and indicated that she should not have started a bath that she could not finish before the end of her shift.
*CNA K indicated that when she left the whirlpool tub room on 4/28/25, resident 40 was in the whirlpool tub, and CNA Q had agreed to complete resident 40's whirlpool bath; however, CNA K saw CNA Q leave the whirlpool tub room and heard CNA Q state that she "would be right back."
*CNA K had not worked with CNA Q before that incident and thought that CNA Q would have

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finished resident 40's whirlpool bath.
*CNA K stated that staff members carried walkie-talkies to communicate with each other, but resident 40 had no way to alert staff of her need for assistance, while in the whirlpool, except to yell for help.
*CNA K thought that resident 40 was safe to be in the whirlpool tub unattended for a short period because resident 40 was independent with bathing and dressing, did not need physical assistance with bathing while in the whirlpool tub, and had requested to rinse herself off with the hand-held shower.
*CNA K could not recall if she had been told before that incident that residents were not to be left alone in the whirlpool tub.

7. Interview on 6/26/25 at 11:40 a.m. with CNA O revealed:
*On 4/28/25 she had heard CNA K tell CNA Q that she needed to leave at the end of her shift [3:30 p.m.] and that CNA Q had agreed to complete resident 40's whirlpool bath.
*She did not know that CNA K and CNA Q had left resident 40 alone in the whirlpool tub.
*She heard someone inside the whirlpool tub room say, "Hello, I am done," from the nurses' station.
-She stated that resident 40's voice was calm.
*When CNA O entered the whirlpool tub room, resident 40 was in the tub and no staff were present.
*Resident 40 indicated that she was finished soaking and was ready to get out of the whirlpool tub, and then CNA Q arrived and assisted resident 40 out of the whirlpool tub.
*CNA O was trained that for the resident's safety, she was never to leave a resident alone in the whirlpool tub or the shower, even if they were

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independent or requested to be alone.

8. Interview on 6/26/25 at 12:24 p.m. with DON B and Minimum Data Set (MDS)/ registered nurse (RN) C regarding the incident with resident 40 on 4/28/25 revealed:
*MDS/RN C had completed a skin assessment of resident 40 after that bath, and there were no concerns noted. Resident 40 stated she had enjoyed her bath.
*DON B expected that the staff would remain in the whirlpool tub room for the entire time any resident was in the whirlpool tub for the resident's safety.
*MDS/RN C stated no current resident was independent in the shower or the whirlpool tub.
*Resident 40 should not have been left alone in the whirlpool tub.
*CNAs were educated during their orientation that they needed to remain in the whirlpool tub room with a resident while they showered or took a bath, and that staff members could use the call light or walkie-talkies to call for help from other staff if needed.

9. Review of the provider's 3/13/25 SD DOH FRI revealed:
*Resident 38 was standing at the foot of her bed in front of her dresser when CNA S entered her room.
*CNA S "walked to [the] head of the bed while resident [38] remained at the foot of the bed," to pull down the sheets.
*Resident 38 fell "backward without warning and hit the back of her head."
*Resident 38 was sent to the emergency department (ED) to be "evaluated as she hit the back of her head and edema [swelling] was present ..."

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*Resident 38 reported headache, and pain to her "head, neck, back, chest and pelvis since falling."
*While at the hospital ED resident 38 experienced an "episode of hypoxia [low level of oxygen in the body] after IV [intravenous] Fentanyl [a pain medication]" with oxygen levels in the 80s and required 5 liters (L) of oxygen by nasal cannula (NC) (a flexible tubing that delivers oxygen through the nose) and returned to the facility on 1L of oxygen by NC.
*Resident 38 required "SBA [standby assistance of one staff member] with a walker in and out of her room.
*"CNA [S] should have assisted the resident to a safe position prior to pulling down the sheets in the bed and should not have left resident [38] standing by the dresser..."

10. Review of resident 38's EMR revealed:
*She was admitted on 12/3/24.
*Her 3/11/25 BIMS assessment score was 0, which indicated she was severely cognitively impaired.
*Her 12/16/24 revised care plan indicated she required the assistance of one staff member with her walker. Resident 38 "does need extra assistance if she is having extra pain and other times she will forget that she needs assistance and [will] get up without assistance."
*Her 3/20/25 revised care plan indicated she required "SBA" of one staff member with her walker ..."
*Her 3/11/25 fall risk assessment indicated she was at high risk for falls and knew her own limits.
*A 3/13/25 progress note indicated, "Resident [38] was standing by her dresser and fell backwards hitting her head on her the bathroom door. Injuries: edema on the back of her head. 10/10 [ten on a zero to ten pain scale] generalized pain

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F 689	Continued From page 21 ... Resident transferred to ED for evaluation." 11. Observation and interview on 6/24/25 4:08 p.m. with resident 38 revealed: *She was seated in her recliner with her call light next to her. *Her room was arranged as described in the FRI with her dresser at the foot of her bed. When the bathroom door was open, it aligned with the dresser. The room was uncluttered with both a wheelchair and a walker present. *She did not remember falling, did not know what she would use the call light for, and indicated that if she needed something, she would just "get up and get it." *She was pleasant, answered basic questions, and denied having any pain. 12. Interview by phone on 6/26/25 at 10:00 a.m. with CNA S revealed: *On 3/13/25, resident 38 was in her room, standing at the foot of her bed, by her dresser with her walker, when CNA S arrived to assist her with getting ready for bed. The dresser drawer was open, and she thought that resident 38 was getting her pajamas from the dresser. *CNA S stated that she had gone to pull back the blankets on the bed when she heard resident 38 fall and hit her head. *Resident 38 was in a lot of pain and called out loudly after she fell. *The nurse came immediately after the resident fell that day and completed an assessment. Resident 38 was sent to the ED for further evaluation. *Resident 38 often got up unassisted. *She had been uncertain if resident 38 was allowed to stand independently at that time. -She had been educated after the resident's	F 689		

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3/13/25 fall that resident 38 required standby assistance and that staff were to remain within arm's reach of the resident when standing with or walking with her.
*The level of staff assistance a resident required could be found in the resident's care plan in the EMR.

13. Interview on 6/26/25 at 11:40 a.m. with DON B revealed:
*Resident 38 had required standby assistance of one staff member at the time of her 3/13/25 fall.
*Resident 38 would often forget that she needed staff assistance and would get up independently.
*She expected staff to assist resident 38 to her destination and to remain within arm's reach of her due to resident 38's fall risk.
*CNA S should have assisted resident 38 to sit down before she turned back the bed linens that day.
*She expected the CNAs to review the resident care plans and to know the level of assistance a resident required when standing or transferring to ensure their safety.

14. Review of the provider's June 2025 Bathing policy revealed:
*"Ensure the resident's safety during bathing."
*"Visit with the resident during bathing and keep conversation focused on his/her interests."
*"Do not leave the resident alone in the shower/tub room. Use the call light if you need assistance."

Review of the provider's 10/31/24 LTC (Long Term Care) Falls and Accidents policy revealed:
*"Supervision/adequate supervision: This determination is based on the individual resident's assessed needs and identified hazards in the

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OAKVIEW TERRACE	510 E 8TH ST FREEMAN, SD 57029

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F 689	Continued From page 23 resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident." *"All staff will be educated about and have access to care plans which are individualized for each resident ..." *"Based on assessment of fall risk ..., staff will implement appropriate individualized, resident-centered interventions to reduce the likelihood of falls ... and communicate the risk and interventions to the staff through the plan of care.	F 689		
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732	The facility will ensure all charge nurses, including DON B and RN H, will post daily nursing staffing information that includes the facility name, total number of staff hours, and the actual hours worked by nursing staff. On 7/14/2025, Administrator and Assistant Administrator reviewed the Nursing Daily Staffing Information Posting policy, including "The facility posts the following information on a daily basis: 1. Facility name 2. The current date 3. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides. 4. Resident census. The facility must post the nurse staffing data mentioned above on a daily basis at the beginning of each shift." On 7/16/2025, Daily Nursing Staffing Information Posting sheet was updated to include:	8/7/2025

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F 732	Continued From page 24 (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the provider failed to post the required daily nursing staffing information that included the facility name, total number of staff hours. and the actual hours worked by nursing staff for 33 or 33 random days reviewed in March, April, and June of 2025. 1. Observation on 6/24/25 at 9:39 a.m. of the posted nurse staffing information revealed: *It was posted on a board near the nurses' station. *It did not contain the name of the facility as required. *There were six categories of staff listed on the sheet: RN (registered nurse), LPN (licensed practical nurse), CNA (certified nursing assistant), Medication aide, Restorative aide, and shift totals. *Within each of those categories the number of staff scheduled for the day was listed by shift. *There was one RN listed for each identified shift. *The CNA area under the 6:00 a.m. to 2:00 p.m. shift indicated there were six CNAs working within the facility during that time frame.	F 732	• Facility name • The current date • The total number and actual hours worked by all licensed and unlicensed staff. On 7/16/2025, posted Daily Nursing Staffing sheet was relocated from bulletin board to Nurses' Station counter. On 7/17/2025, Assistant Administrator reviewed and educated RN H and DON B on Nursing Daily Staffing Information Posting policy. By 7/22/2025, all Licensed Nurses including RN H & DON B will receive education including the Nursing Daily Staffing Information Posting policy. Education and attestation of completion and understanding is to be completed by 8/7/2025. All employees on prn or on leave of absence status will complete this education prior to their return to work. Beginning on 7/16/2025, DON or designee will perform Nursing Daily Staffing Posting audits daily Monday through Friday for 8 weeks to ensure total number & actual hours worked by all nursing staff and resident census is accurately completed. Assistant Administrator will report the result of the audits to QAPI committee weekly. The QAPI committee will direct further audits.	

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*There were no documented actual or total hours worked on the form for nursing staff as required.

2. Review of the 6/24/25 nursing staff assignment sheet revealed:
*There had been a staff member who was "ILL" for the 6:00 a.m. shift.
*The staff member who had called in ill was not replaced by another CNA on the assignment sheet, which indicated there were only five CNAs present for that 6:00 a.m. shift.
*Nurses in management roles were not listed on the assignment sheet.

3. Interview on 6/25/25 at 2:14 p.m. with RN H revealed:
*The night nurse was responsible for completing the daily staffing sheet and posting it on the board near the nurses' station.
*The numbers entered on the daily staffing sheet were gathered from the nursing staff assignment sheet, which listed the staff who were scheduled to work for the upcoming day.
*She verified the CNA that was documented on the assignment sheet on 6/24/25 as "ILL" was not replaced by another staff member.
*She verified the 6/24/25 daily staffing sheet was not updated to reflect the staff present during that shift.
*She indicated if someone called in or did not show up for their shift, the daily staffing sheet would not be updated to reflect the actual number of staff present in the facility that day.
*Nurses in management positions, such as the Minimum Data Set (MDS) nurse and the director of nursing (DON), were not included in the nursing staff numbers reflected on the daily staffing sheet.
*The actual and total number of hours worked

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F 732	Continued From page 26 were not calculated and documented on the daily staffing sheet. 4. Interview on 6/26/25 at 12:09 p.m. with DON B revealed: *She expected the daily staffing form to be adjusted if there was a staff member call in to accurately reflect the number of staff working in the facility for the shift. *She verified there was no facility identification on the daily staffing form as required. *She agreed the daily staffing form did not reflect the actual staff hours worked, or the total number of staff hours worked as required. Review of the provider's June 2025 Nursing Daily Staffing Information Posting policy revealed: *"The facility posts the following information on a daily basis: -1. Facility name -2. The current date -3. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides. -4. Resident census". *"The facility must post the nurse staffing data mentioned above on a daily basis at the beginning of each shift."	F 732		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812	The facility will ensure food is stored, labeled, dated, and disposed of per provider's policy and temperatures are monitored and addressed when out of range according to provider's policy in the Southview, Northview, and Clean Utility refrigerators. On 7/15/2025, Administrator and Assistant	8/7/2025

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F 812	Continued From page 27 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure: *Food was stored labeled, dated, and disposed of according to the provider's policy in three of three unit refrigerators and freezers. *Temperatures were monitored and addressed when out of range according to the provider's policy in three of three unit refrigerators and freezers. Findings include: 1. Observation on 6/24/25 at 8:58 a.m. of the Southview refrigerator and freezer revealed: *The posted June 2025 refrigerator and freezer temperature log was missing several temperature entries. *On the left side of the refrigerator was an external digital thermometer with an internal probe. The external digital display was not functional. *Inside the refrigerator, a thermometer read 42 degrees Fahrenheit (F).	F 812	Administrator reviewed and retired Fridge policy and reviewed & retired the Refrigerator Use: Resident Policy & Procedure and adopted LTC Food Safety and Sanitation - FRHS Specific Info policy including: • "Foods brought in by residents, families or visitors are subject to compliance of facility policy. • Fruits, vegetables, dairy products, meat and poultry are stored at temperatures between 40° F and 33° F (4.4°C and 0.5°C). Fish, ice cream, and frozen foods are stored at temperatures of 0°F (-17°C) or below. Thawed raw food is not to be refrozen. • All perishable food items are labeled and dated prior to refrigeration or freezing. • Food is served as soon as possible. Leftover food is treated as recommended by Food Service Code. All leftover food is discarded after 3 days (72 hrs). • Frozen food will be discarded after its expiration date. • All refrigerators and freezers have thermometers and temperature is documented at least 1x daily. • Maintenance is to be notified if refrigerator temperature is above 40° F (4.4°C) and freezer temperature is above 0°F (-17°C), On 7/16/2025, DON and Maintenance Director placed the Southview refrigerator out of service. The Southview refrigerator was unplugged and an Out of Service sign was placed on the refrigerator until it is able to be physically removed from the unit. On 7/16/2025, DON placed new glycol thermometers in the Northview and Clean Utility refrigerators and freezers. On 7/16/2025, the "Refrigerator Temperature Check Form" was updated to ensure accurate	

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F 812	Continued From page 28 *The refrigerator contained: -A plastic tub with an open one-pound block of butter covered with tin foil, which was not labeled or dated. -An open container of applesauce dated "Best by 2/26/25," that was labeled "Act." *Inside the freezer, a thermometer read 22°F. *The freezer contained an open container of chocolate peanut butter ice cream labeled with resident 38's name and dated "6/22." 2. Observation on 6/24/25 at 10:10 a.m. of the Northview refrigerator and freezer revealed: *It contained two locks. The freezer was locked, but the refrigerator was not locked. *The posted June 2025 refrigerator and freezer temperature log was missing several entries. 3. Observation on 6/25/25 at 8:03 a.m. of the room behind the nurses' station labeled "Clean Utility" revealed: *There was an ice machine and a refrigerator in the room. *The June 2025 Kitchenette Refrigerator/Freezer Temperature form posted on the refrigerator door had areas for the temperatures of the refrigerator and freezer to be documented twice daily, once in the AM (morning), and once in the PM (evening). *The Refrigerator/Freezer Temperature form indicated the temperature range for the refrigerator was 35 to 40 [degrees] F and the range for the freezer was 0 [degrees] F or less. -There were no documented temperatures in the AM areas for the refrigerator or freezer on June 5, 7, 8, and 15. -The documented refrigerator temperatures were below 32 degrees Fahrenheit 14 times. -The refrigerator temperatures were documented above 41 degrees F on June 18 at 45 degrees F,	F 812	tracking of refrigerator temperatures, notification of times when out of range, and appropriate food labeling, dating and disposals. On 7/16/2025, Assistant Administrator reviewed and educated RN I, CNA M, Food Services Supervisor G, Director of Quality and Infection Control E, CNA U, & DON B on the LTC Food Safety and Sanitation - FRHS Specific Info policy and provided education: • on operation of new thermometers, • that “Refrigerator Temperature Check Form” was updated to ensure accurate tracking of refrigerator temperatures, notification of times when out of range, and appropriate food labeling, dating and disposals • that Nursing is responsible for Northview refrigerator temperatures and food labeling and disposal per policy, • that Nutrition Services is responsible for Clean Utility refrigerator temperatures and food labeling and disposal per policy. • that the Northview & Clean Utility refrigerators are monitored twice daily By 7/22/2025, all direct care staff including RN I, CNA M, Food Services Supervisor G, Director of Quality and Infection Control E, CNA U, & DON B will receive education including: • the “LTC Food Safety and Sanitation-System Standard Policy,” • operation of new thermometers, • that the “Refrigerator Temperature Check Form” was updated to ensure accurate tracking of refrigerator temperatures, notification of times when out of range, and appropriate food labeling, dating and disposals, • that Nursing is responsible for Northview Refrigerator temperatures and for labeling	

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F 812	Continued From page 29 19 at 42 degrees F, 21 at 42 degrees F, and 23 at 42 degrees F. *Inside the refrigerator was: -A Ziploc bag of crumbled dry muffins that was not labeled with a name or a date. -A plastic container that was labeled with a resident's name but did not have a date on it. -A Cool Whip container that was labeled with resident 6's name and the date 6/12/25 that had mixed fruit with a layer of mold growing on the surface of the fruit. *Inside the freezer there was an unlabeled and undated partial 1.5-quart container of vanilla ice cream that had appeared to have been melted and refrozen due to the surface of the inside of the container was covered in clear crystals. *There were no interventions for the out-of-range temperatures documented on the form 4. Review of the April and May 2025 Kitchenette Refrigerator/Freezer Temperature forms revealed: *None of the documented refrigerator temperatures for the month of April 2025 were above 30 degrees F. *All but the 5/4/25 documented refrigerator temperatures in May 2025 were 32 degrees F or less. *There were no documented interventions for the out-of-range temperatures documented on the form. 5. Interview on 6/26/25 at 8:08 a.m. with registered nurse (RN) I revealed: *She was not sure who was responsible for monitoring the temperatures of the unit refrigerators and freezers. *She verified there were out of range temperatures documented for the kitchenette	F 812	and food labeling and disposal per policy, • that Nutrition Services is responsible for Clean Utility refrigerator temperatures and food labeling and disposal per policy, • that the Northview and Clean Utility refrigerators are monitored twice daily, and • the Southview refrigerator is “out of service,” unplugged, and not to be used. Education and attestation of completion and understanding is to be completed by 8/7/2025. All employees on prn or on leave of absence status will complete this education prior to their return to work. Beginning on 7/16/25, DON will perform 2 Refrigerator audits daily Monday through Friday for 8 weeks to ensure food is stored, labeled, dated, and disposed of per provider’s policy and temperatures are monitored and addressed when out of range according to provider’s policy. Audits will include refrigerators in Northview & Clean Utility (behind nurses’ station). Assistant Administrator will report the result of the audits to QAPI committee weekly. The QAPI committee will direct further audits.	

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refrigerator freezer in June 2025.
*She agreed there were items in the refrigerator and freezer that were not labeled with the resident's name and date when the item was opened or placed in the refrigerator.
*She verified there was mold on the fruit in the refrigerator, indicated she would not serve that fruit, and that it should be disposed of, but did not dispose of it at that time.
*She verified crystals had formed on the ice cream, and it appeared as the ice cream had been melted and refrozen.
*She indicated she would notify maintenance if she was notified the refrigerator or freezer temperature was out-of-range.
*She was not aware if maintenance had been notified there were documented out-of-range temperatures.

6. Interview on 6/26/25 at 8:41 a.m. with certified nursing assistant (CNA) M revealed:
*She thought the kitchen staff was responsible for monitoring the unit refrigerator and freezers.
*When residents had food brought in from an outside source, staff members were to label the food with the resident's name and date before placing it in the unit refrigerator freezers.
*Both the CNAs and the kitchen staff were responsible for checking the food in the refrigerator for spoiled or outdated foods.
*She did not know what she was to do if she noticed the refrigerator or freezer temperature was out of range.
7. On 6/26/25 at 11:15 a.m., a request was made to DON B for the Northview and Southview refrigerator temperature logs for April, May, and June 2025. The logs for May 2025 were unavailable for review.

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8. Review of the Southview Refrigerator/Freezer Temperature Forms revealed:
*"REPORT ALL OUT OF RANGE TEMPS [temperatures] TO THE DIETARY MANAGER AT TIME NOTED."
*The refrigerator range was listed as "35-40 F," and the freezer range was "0 OR LESS."
*In April 2025:
-There were 15 days with no refrigerator or freezer AM temperatures recorded.
-There were no PM temperatures recorded.
-The form indicated the refrigerator was out of the range six days.
*In June 2025:
-There were 14 days with no refrigerator or freezer AM temperature recorded.
-There were no PM temperatures recorded.
-On 6/3/25, the refrigerator was out of the range indicated on the form.
*There were no documented interventions for out-of-range temperatures documented on the form

9. Review of the Northview Refrigerator/Freezer Temperature Forms revealed:
*In April 2025:
-There were five days with no refrigerator or freezer AM temperatures documented.
-There were 12 days with no refrigerator or freezer PM temperatures documented.
-On 4/2/25, the refrigerator and freezer were documented as being over the temperature range indicated on the form.
-All other documented refrigerator temperatures were below the refrigerator temperature range.
*There were no interventions for the out-of-range temperatures documented on the form.
*In June 2025:
-On 6/19/25, no refrigerator or freezer AM

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temperature was documented.
-There were eight days with no refrigerator or freezer PM temperatures documented.
-On 6/2025, the freezer was documented as being over the temperature range indicated on the form.
-There were 33 documented refrigerator temperatures below the refrigerator temperature range.
*There were no interventions for out-of-range temperatures documented on the form.

10. Interview on 6/25/25 at 10:46 a.m. with food services supervisor G regarding the unit refrigerator and freezers revealed:
*He expected the "kitchenette refrigerator" behind the nurses' station and the Northview refrigerator temperatures to have been monitored by the nursing staff.
*The dietary staff provided snacks and beverages for the residents upon request.
*Opened food items were to be dated and labeled by the dietary staff when they were removed from the kitchen.
*He expected the nursing staff to date and label food items when they opened them on the unit.
*He expected resident's food items not to be stored in the Southview refrigerator.

11. Interview on 6/25/25 at 4:20 p.m. with director of quality and infection control E regarding the unit refrigerators revealed:
*She expected the Southview refrigerator and freezer not to have been used to store resident food.
-That refrigerator had been put out of service and was to have been removed from the Southview unit.
-She was unaware that the refrigerator contained

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an open applesauce dated "Best by 2/26/25," and that the freezer contained an open ice cream container labeled with resident 38's name.
*She expected the nursing staff to monitor and document the refrigerator and freezer temperatures of the Northview refrigerator and freezer twice daily.
*Nursing staff were also responsible for dating and labeling food items when they were opened and discarding those items when they were spoiled. She was not sure how many days the food items could remain in the refrigerator safely.

12. Interview on 6/26/25 at 8:17 a.m. with certified nursing assistant (CNA) U regarding the Northview refrigerator revealed:
*The Northview refrigerator and freezer were locked because they were in the memory care unit (an area where specialized care is provided in a structured, safe, and supportive environment to meet the unique needs of residents with significant memory and cognitive decline, that is secured to minimize unsafe wandering), and residents might have opened the refrigerator and taken items that did not belong to them.
*The CNAs were responsible for monitoring and documenting the temperatures of the refrigerator and the freezer twice a day.
*The kitchen delivered requested food items to the unit from the main kitchen. Those items were to be labeled and dated by the kitchen staff if they were already open. Nursing staff were to label and date food items when they opened them on the unit.
*She would have notified the nurse if there was a problem with the refrigerator.

13. Interview on 6/26/25 at 12:09 p.m. with director of nursing (DON) B revealed:

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F 812	Continued From page 34	F 812		

*The nursing staff was responsible for monitoring the unit refrigerator and freezer temperatures during the day, and the dietary staff was responsible for the temperature monitoring in the evening.
*She expected that food placed in the unit refrigerators would be labeled with the resident's name and dated.
*Food brought in for a resident was to be disposed of three days after opening.
*She did not know the expectation for how food that was brought in for a resident was to be stored in the freezer.
*She expected the nursing staff would have removed the food from the refrigerator that was not labeled with a resident identification, date, or was spoiled.
*She expected maintenance be notified of temperatures that were out of range.
*She expected an intervention to be documented on the temperature form if an out-of-range temperature was identified.
*She verified there were multiple temperatures out of their policy's identified range between April 2025 and June 2025 with no documented interventions on the forms.

Review of the provider's June 2025 Fridges policy revealed:
*"All refrigerators and freezers have thermometers and temperature is documented at least 1x [one time] daily."
*"Maintenance is to be notified if [the] refrigerator is above 40°F and freezer temperature is above 0°F."
*"Fridge temperatures should be between 40°F and 33°F. Freezer temperatures should be 0°F or below.
*"Food is served as soon as possible. All leftover

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F 812	Continued From page 35 food is discarded after three days (72 hours)." Review of the provider's April 2025 Refrigerator Use policy revealed: *"Food needing refrigeration will be labeled with the resident's name and dated and stored in the facility's refrigerator in the kitchenette behind the nurses station."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880	The facility will ensure that resident 11 and all other residents will receive care from CNA L, CNA M, CNA T, CNA/CMA J and all other direct care staff following infection control practices for the storage and handling of a catheter urine drainage bag and the cleaning and disinfecting of shared resident lift equipment. On 7/15/2025, Director of Nursing confirmed that disinfectant wipes were present on all the mechanical lifts including the full body mechanical lift labeled hoyer 1, Sara Plus sit-to stand lift, the EZ Stand sit-to-stand mechanical lift, and the Tollos Steady Aid sit-to-stand lift. On 7/16/2025, additional Sara Plus sit-to stand lift & EZ Stand sit-to-stand mechanical lift slings were ordered to allow for individual resident use. Slings are to be delivered by 7/24/2025 at which time each resident using a mechanical lift, including resident 11, will have an individual sling and slings will be stored in each resident room. Slings will be laundered when visibly soiled and between resident use. On 7/15/2025, Administrator and Assistant Administrator reviewed FRHS LTC - Disinfection of Non-Critical Resident Care Equipment - System Standard Policy - FRHS Specific Info, which includes:	8/7/2025

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F 880	Continued From page 36 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 880	• Cleaning, disinfecting and storing equipment and supplies is important in preventing the transmission of potential pathogens within the long-term care facility. • For the safety and comfort of residents, all reusable ("non-critical") resident care items will be cleaned, disinfected and maintained in a safe manner between resident uses." • Noncritical resident care items ...are cleaned between/after each resident use. They require Low level disinfection by cleaning following manufacturer instructions with an EPA [Environmental Protection Agency]-registered disinfectant detergent, or germicide that is approved for healthcare settings. • Disinfection Recommendations- Reusable resident care equipment: All applicable instructions on EPA-registered disinfectant products must be followed ...Between each resident use and when soiled ...Lifts." and updated to include: "Slings are to be laundered for disinfection per manufacturer's recommendations. EPA-registered disinfectant products do not indicate applicable material compatibility for cloth." By 7/2/2025, DON ensured that resident 11 and all other residents' drainage bags were not touching the floor nor hanging on trash cans and were placed in privacy bags hanging on hooks on furniture below residents' bladder level. On 7/15/2025, Administrator and Assistant Administrator reviewed the LTC - Perineal Care - System Standard Policy - FRHS Specific Info, including "Residents with an IUC [indwelling urinary catheter]…	

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F 880	Continued From page 37 and policy review, the provider failed to ensure infection control practices were followed for: *The storage and handling of a catheter urine drainage bag for one of one sampled resident (11) with a catheter. *The cleaning and disinfecting of shared resident lift equipment by three of three observed certified nursing assistants (CNAs) (L, M, and T) Findings include: 1. Observation on 6/24/25 at 9:38 a.m. of resident 11's room revealed: *A sit-to-stand lift (mechanical lift used to assist from a seated to a standing position) was outside of resident 11's room with a safety sling draped over the top. *A small blue bag was attached to that lift. -There were no disinfectant wipes available to use in the bag. *Resident 11's uncovered catheter bag was hooked on the edge of her trash can which was on the right side of her recliner. 2. Observation on 6/24/25 at 10:32 a.m. outside of resident room 108 revealed: *There was a Sara Plus sit-to-stand lift with a purple sling draped over the top of it. -There were no disinfectant wipes available to use on that lift. 3. Observation on 6/24/25 at 2:16 p.m. of resident lifts parked in the 300-hall revealed: *The full body mechanical lift (a mechanical lift with a body sling used to lift a person's full body) labeled "hoyer 1" had a container of glass cleaner wipes in the bag attached to the lift. -There were no disinfectant wipes available to use in that bag. *The EZ Stand sit-to-stand mechanical lift had a	F 880	• Hang [the] drainage bag • Ensure bag is not touching the floor • Prevent the drain spout from touching the floor” and updated to include: • Enhanced Barrier Precautions are also a reason to don PPE. • Wipe off the tip of the drain/spout with an alcohol swab before and after draining urine from the bag and if the drain/spout contacts any surface. On 7/15/2025, Administrator & Assistant Administrator reviewed the FRHS Hand Hygiene - FRHS Specific Info Policy including: • “Hand Hygiene (HH) continues to be the primary means of preventing the transmission of infection…to provide a clean and healthy environment for residents, staff, and visitors. • HH, either with soap and water or with alcohol based hand rub (ABHR) [is to be completed] • before a clean procedure or handling an invasive device • after removing gloves." On 7/15/2025, Administrator and Assistant Administrator reviewed LTC - Transmission Based Precautions and Enhanced Barrier Precautions - FRHS Specific Info Policy, including: • “Enhanced Barrier Precautions are used during high contact resident care activities for the following residents…indwelling medical device, regardless of MDRO status (e.g. central line, urinary catheter, feeding tube, trach) • gown and gloves must be used during high contact resident care activities including…device care or use (Central lines, urinary catheter, feeding tube, trach	

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F 880	Continued From page 38 large sling draped over the lift while it was in the hallway -That lift did not have disinfectant wipes available to use on the lift or in the bag attached to it. 4. Observation and interview on 6/24/25 at 3:12 p.m. with resident 11 and CNA/certified medication aide (CMA) J, outside resident 11's room revealed: *There was an orange ribbon symbol under resident 11's nameplate outside her room. CMA/CNA J explained that the orange ribbon indicated that resident 11 had a urinary catheter. *Resident 11 was able to answer simple questions but was not aware of where her urinary catheter drainage bag was stored. *Resident 11's urinary catheter drainage bag was hanging from her trash can. The drainage spout was unhooked from its storage slot and was touching the floor. *CNA/CMA J confirmed that the resident's urinary catheter drainage bag was hanging from the trash can and that the spout was touching the floor. *Without performing hand hygiene (hand washing or the use of hand sanitizer) or putting on a gown CMA/CNA J put on a pair of gloves and, without using a disinfectant, placed the drainage spout back into the storage slot on the urinary catheter drainage bag. *She stated, "It [the spout] must have come loose." *She stated that when resident 11 sat in her recliner, they would hang the urinary catheter drainage bag from the trash can to keep it off the floor. They did not use a catheter protective or privacy bag cover when resident 11 was in her room. *CMA/CNA J stated they used the privacy bag attached to the wheelchair to store resident 11's	F 880	adjustment/care) • Hand hygiene is per the FRHS/Avera LTC Hand Hygiene policy." On 7/15/2025, Administrator and Assistant Administrator reviewed the following CNA competency checklists: • Emptying and Changing a Urinary Catheter Bag Checklist, & • Enhanced Barrier Precautions & Hand Hygiene Checklist. On 7/16/2025, Assistant Administrator reviewed & educated CMA/CNA J on the: • FRHS LTC - Perineal Care - System Standard Policy - FRHS Specific Info, • FRHS Hand Hygiene - FRHS Specific Info Policy, and • FRHS LTC - Transmission Based Precautions and Enhanced Barrier Precautions - FRHS Specific Info Policy. On 7/16/2025, Assistant Administrator reviewed and educated CNA M on the: • FRHS LTC - Disinfection of Non-Critical Resident Care Equipment - System Standard Policy - FRHS Specific Info, • FRHS LTC - Perineal Care - System Standard Policy - FRHS Specific Info, and • FRHS Hand Hygiene - FRHS Specific Info Policy. On 7/17/2025, Assistant Administrator reviewed and educated CNA T on the: • FRHS LTC - Disinfection of Non-Critical Resident Care Equipment - System Standard Policy - FRHS Specific Info, • LTC - Perineal Care - System Standard Policy - FRHS Specific Info, and • FRHS Hand Hygiene - FRHS Specific Info Policy. On 7/16/25, Assistant Administrator reviewed	

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F 880	Continued From page 39 urinary catheter drainage bag when she left her room. *CMA/CNA J removed her gloves and, without completing hand hygiene, she left the residnet's room. 5. Review of resident 11's electronic medical record revealed: *She was admitted on 11/18/24. *Her diagnosis included neuromuscular dysfunction of the bladder. *Her 5/27/25 Brief Interview of Mental Status (BIMS) assessment score was 2, which indicated she was severely cognitively impaired. *A 5/20/25 physician's order indicated "Foley catheter ...only change when compromised or leaking." 6. Observation on 6/25/25 at 7:52 a.m. of the soiled utility room revealed: *There was an EZ Stand sit-to-stand lift with a sling draped over it. *There was a Tollos Steady Aid sit-to-stand lift that did not have disinfectant wipes available to use n the lift. *There was a Sara Plus sit-to-stand lift with a sling draped over it. 7. Observation and interview on 6/25/25 at 11:00 a.m. of CNA M and CNA T and resident 11 revealed: *Resident 11's urinary catheter drainage bag was lying on the floor in front of her trash can. *The Tollos Steady Aid sit-to-stand lift was outside her room with the safety sling draped over the top of it. -There were no disinfectant wipes on that lift available to use. *CNA M and CNA T brought the Tollos Steady Aid	F 880	educated CNA L on the FRHS LTC - Disinfection of Non-Critical Resident Care Equipment - System Standard Policy - FRHS Specific Info. On 7/16/2025, Assistant Administrator reviewed and educated Director of Quality & Infection Control E and DON B reviewed and educated on the: • FRHS LTC - Disinfection of Non-Critical Resident Care Equipment - System Standard Policy - FRHS Specific Info, • LTC - Perineal Care - System Standard Policy - FRHS Specific Info, • FRHS Hand Hygiene - FRHS Specific Info Policy, & • FRHS LTC - Transmission Based Precautions and Enhanced Barrier Precautions - FRHS Specific Info Policy. By 7/22/2025, all direct care staff including, Director of Quality & Infection Control E, DON B, CMA/CNA J, CNA L, CNA T, and CNA M, will receive education which includes: • FRHS LTC - Disinfection of Non-Critical Resident Care Equipment - System Standard Policy - FRHS Specific Info policy. • FRHS LTC - Perineal Care - System Standard Policy - FRHS Specific Info • FRHS Hand Hygiene - FRHS Specific Info Policy, • FRHS LTC - Transmission Based Precautions and Enhanced Barrier Precautions - FRHS Specific Info Policy, & • Emptying and Changing a Urinary Catheter Bag & Enhanced Barrier Precautions & Hand Hygiene Competency Checklist demonstration. Education and attestation of completion and understanding is to be completed by 8/7/2025. All employees on prn or on leave of absence status will complete this education prior to their	

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F 880	Continued From page 40 sit-to stand lift with the sling draped over the top into resident 11's room and put on gowns and gloves. *CNA T confirmed that resident 11's urinary catheter drainage bag was lying on the floor, and with her gloved hands, she then hung the catheter bag on the edge of the trash can. *CNA T stated that when the catheter was attached to resident 11's right leg, they would hang the urinary catheter drainage bag from the trash can, and when the catheter was attached to resident 11's left leg, they would hang it from her chairside table. *CNA M emptied resident 11's urinary catheter drainage bag using a container with graduated measurements on it. *Without changing their gloves, CNA M and CNA T placed the lift safety sling around resident 11, attached that sling to the lift, and transferred resident 11 from her recliner to the wheelchair. *CNA M stated that each sit-to-stand lift had a safety sling that was to be kept with that lift. The safety sling would be used for transferring any resident who required the use of the lift, and any of the sit-to-stand lifts could be used with any resident. *CNA T stated that there were no disinfectant wipes on the lift, left, then returned with two wipes. She used one wipe to wipe the lift and a second to wipe the safety sling. *She stated those wipes were retrieved from the "purple top container at the nurses' station." 8. Observation and interview on 6/26/25 at 8:52 a.m. with CNA L in the 200 hallway revealed: *She was cleaning the Sara Plus sit-to-stand lift with a wipe. *She stated that the sit-to-stand lifts were shared between all the residents who required that style	F 880	return to work. Beginning on 7/16/2025, DON or designee will perform 3 Catheter Bag Audits weekly for 8 weeks to ensure appropriate infection control practices for storage of a catheter urine drainage bag. Audits will include Resident 11. Assistant Administrator will report the result of the audits to QAPI weekly. The QAPI committee will direct further audits. Beginning on 7/21/2025, DON or designee will perform 3 Catheter Emptying Observational Audits weekly for 8 weeks to ensure appropriate infection control practices for the handling of catheter urine drainage bags. Audits will include Resident 11. Assistant Administrator will report the result of the audits to QAPI weekly. The QAPI committee will direct further audits. Beginning on 7/28/2025, DON or designee will perform 3 Lift Disinfection and Sling Verification Audit weekly for 8 weeks to ensure appropriate infection control practices for the cleaning and disinfecting of shared resident lift equipment. Audits will include Resident 11. Assistant Administrator will report the result of the audits to QAPI weekly. The QAPI committee will direct further audits. Beginning on 7/16/2025, DON or designee will perform 3 Hand Hygiene audits weekly for 8 weeks to ensure appropriate hand hygiene is completed appropriately per policy. Audits will include Resident 11. Assistant Administrator will report the result of the audits to QAPI committee weekly. The QAPI committee will direct further audits. Beginning on 7/16/2025, DON or designee will perform 3 Enhanced Barrier Precautions audits	

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F 880	Continued From page 41 of lift and that there was one safety sling for each sit-to-stand lift. Those safety slings were stored on the lift. *The shared lifts and safety slings were to be wiped down between each resident's use with a "Sani-wipe [disinfectant]." *She used one wipe to wipe the surfaces of the lift and a second wipe to wipe the cloth safety sling. -She was unsure if there was a specific amount of time that the surface of the shared lift sling would need to remain wet to ensure that it had been disinfected between each resident use. *She left and then returned and stated there was no specific amount of time that the shared safety sling would need to remain wet, and as long as it was dry, it was ready to use with the next resident. *The full-body mechanical lifts were also shared by residents, however, each resident who used the full-body lift had individual lift slings because that sling was left under the resident in their chair for future use. 9. Interview on 6/25/25 at 5:19 p.m. with director of quality and infection control E and director of nursing (DON) B revealed: *Resident 11's urinary catheter drainage bag should not have been stored on the floor or hung on the trash can to prevent contamination. They had not considered where it should have hung, but they expected that there would have been a barrier between the bag and the floor or the trash can. *DON B confirmed that the resident's urinary catheter bag's drainage spout should have been cleaned with an alcohol pad after being in contact with the floor, before it was placed back in the catheter bag's holder.	F 880	weekly 8 weeks to ensure appropriate hand hygiene is completed appropriately per policy. Audits will include Resident 11. Assistant Administrator will report the result of the audits to QAPI committee weekly. The QAPI committee will direct further audits.	

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F 880	Continued From page 42	F 880		

*DON B confirmed the CNAs should have changed their gloves and used hand hygiene after having emptied the catheter and having been in contact with the drainage spout before using the shared sit-to-stand lift and shared safety sling.
*DON B confirmed that the lifts and the sit-to-stand safety slings were shared by all residents requiring the use of those lifts. The sit-to-stand safety slings were stored with those lifts in the hallway.
*They expected that the "purple top Sani-wipes" would have been stored with each lift and used to clean and disinfect the lift and the cloth safety sling between each resident's use.
*They were unaware that the shared cloth sit-to-stand safety lift slings may not have been adequately cleaned between each resident's use.
*DON B confirmed that the sling's fabric surface would not be able to maintain a wet time to ensure that it had been cleaned or disinfected.

10. Review of the Super Sani-Cloth Germicidal Disposable Wipe product label revealed:
*"To disinfect and deodorize hard, nonporous surfaces: If present, use a wipe to remove visible soil prior to disinfecting. Unfold a clean wipe and thoroughly wet surface. Allow surface to remain wet for two [2] minutes. Let air dry ..."
-There were no instructions for use to disinfect a cloth surface.

11. Review of the provider's April 2025 Perineal Care policy revealed:
*" Residents with an IUC [indwelling urinary catheter] ... Hang [the] drainage bag ... ensure bag is not touching the floor ..."
*"Prevent the drain spout from touching the floor ..."

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F 880	Continued From page 43	F 880		

12. Review of the provider's 11/14/24 Hand Hygiene policy revealed:
*"Hand Hygiene (HH) continues to be the primary means of preventing the transmission of infection ...To provide a clean and healthy environment for residents, staff, and visitors."
*"HH, either with soap and water or with alcohol based hand rub (ABHR): ...2. before a clean procedure or handling an invasive device ... 5. After removing gloves."

13. Review of the manufacturer's Sara Plus Sling Cleaning Instructions revealed:
*In order to obtain a sufficient level of disinfection, machine wash the sling at 158 degrees Fahrenheit (F).
*If allowed according to product label, tumble dry at a low temperature, maximum 140 degrees F.

14. Review of the manufacturer's EZ Way Smart Stand Operator's Instructions did not include instructions for disinfecting the safety sling between resident uses.

15. Review of the manufacturer's Tollos Steady Aid safety sling instructions revealed: "Reusable slings should be laundered between patients."

16. Review of the provider's April 2025 Disinfection of Non-Critical Resident Care Equipment policy revealed:
*"Cleaning, disinfecting and storing equipment and supplies is important in preventing the transmission of potential pathogens within the long-term care facility."
*"For the safety and comfort of residents, all reusable ("non-critical") resident care items will be cleaned, disinfected and maintained in a safe

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	435112	A. BUILDING _____ B. WING _____	C 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	510 E 8TH ST FREEMAN, SD 57029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 44 manner between resident uses." *"Noncritical resident care items ...are cleaned between/after each resident use. They require Low level disinfection by cleaning following manufacturer instructions with an EPA [Environmental Protection Agency]-registered disinfectant detergent, or germicide that is approved for healthcare settings." *"Disinfection Recommendations- Reusable resident care equipment: All applicable instructions on EPA-registered disinfectant products must be followed ...Between each resident use and when soiled ...Lifts & [and] slings."	F 880		