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 01/18/2024

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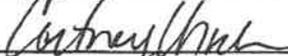
OAKVIEW TERRACE	510 E 8TH ST FREEMAN, SD 57029

(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 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 1/16/24 through 1/18/24. Oakview Terrace was found not in compliance with the following requirements: F550, F604, and F689. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/16/24 through 1/18/24. Areas surveyed included pharmaceutical services and accidents. Oakview Terrace was found not in compliance with the following requirement: F689.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550	The facility will ensure CNA/CMA G, CNA E, CNA F, RN D and all other staff interactions and services are provided in a manner that maintain a sense of dignity & respect for resident 27 and all other residents that require assistance during meal services. By 2/7/24 Assistant Administrator reviewed and educated CNA/CMA G, CNA E, CNA F, and RN D on the FRHS Dignity Policy specifically including avoiding the use of labels for residents such as "feeder" and maintaining an environment that supports appropriate sound and privacy levels. By 2/7/24 Assistant Administrator reviewed and educated CNA E and RN D on FRHS Nutrition: Assisting Residents with Meals Policy and Procedure, specifically including wiping resident face with a separate napkin and not to use silverware to wipe food from a resident's mouth and to serve residents food only from their plate to their mouth.	2/15/24

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


Courtney Unruh | CEO/Administrator | 2/15/2024

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 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure staff interactions and services were provided in a manner that maintained a sense of dignity and respect for residents' that required assistance during one of two observed resident meal services. Findings include: 1. On 1/16/24 at 5:15 p.m. certified nursing assistant/certified medication aide (CNA/CMA) G was asked which dining tables were for the residents who required assistance with eating. She pointed to the last two tables at the north end of the dining room. She stated those were the "feeder tables." There were other residents around when she stated that.	F 550	On 2/6/24 FRHS Dignity Policy and Nutrition: Assisting Residents with Meals Policy and Procedure reviewed and updated by Director of Quality, Assistant Administrator, and Administrator. On 2/5/24 DON completed Leading Age Iowa's Regulation Summation Series-Resident Rights education. On 2/9/24 All direct care staff including DON, CNA/CMA G, CNA E, CNA F, RN D received education titled "Freeman Regional Nursing Home Survey Education-2024" **from Assistant Administrator** which includes FRHS Dignity Policy and Procedure and Nutrition: Assisting Residents Policy and Procedure. Education and attestation of completion and understanding is to be completed by 2/15/24. All employees on prn or on leave of absence status will complete this education prior to their return to work. Beginning on 2/12/24, Assistant Administrator and/or designee will perform 3 Dignity Dining Meal Observations audits weekly for 8 weeks to ensure staff interactions and services are provided in a manner that maintain a sense of dignity & respect for resident 27 and all other residents that require assistance during meal services. Audits will include staff use residents' names or appropriate references, staff maintain an environment that supports appropriate sound and privacy levels, and staff will wipe residents' face, chin and hands with a separate napkin and will serve residents food only from their plate to their mouth. Assistant Administrator and/or designee will report the result of the audits to the QAPI committee weekly. The QAPI committee will direct further audits.	

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F 550	Continued From page 2	F 550		

Observation on 1/16/24 in the main dining room of the residents evening meal revealed at:
*5:20 p.m. CNA E discussed with surveyors in the dining room that there were "two feeder tables and one table for observation."
*5:28 p.m. CNA F asked CNA E "Do you want to feed?" in the dining room in front of the residents while serving resident meals.
*5:36 p.m. CNA E used resident 3's fork to bring food that had spilled out of her mouth onto her chin back into her mouth.
*5:48 p.m. CNA F who was standing next to one of the assisted dining tables called across the dining room in a loud voice to registered nurse (RN) D, who was standing at the entrance to the dining room, "[First name of RN D] do you want to assist with feeders at this table?"
*5:52 p.m. RN D used a spoon to scoop up food that had spilled onto resident 27's clothing protector and put it on her plate. She mixed the food that was scooped up from the clothing protector in with the other food and then gave resident 27 a bite of food.

Interview on 1/18/24 at 3:00 p.m. with administrator A and director of nursing B revealed the above observations had not provided those residents with dignity when they were assisted with eating. The CNA's were given education on the use of the word "feeder" when they referred to residents who required assistance with dining.

Review of the provider's policy on Dignity, last revised December 2021, revealed:
*Staff would interact and carry out activities with residents that assisted in maintaining and enhancing each resident's self-esteem and self-worth.
*Staff should address residents with the name or

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F 550	Continued From page 3 pronoun of the resident's choice, avoiding the use of labels for residents such as feeders.	F 550		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 604	The facility will ensure that resident 27 and all other residents are free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms including a Onesie (one-piece close-fitting garment with opening in the back) restraint to prevent removal of clothing. When the use of restraints is indicated, the facility will use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. On 1/19/24 the DON and MDS nurse reviewed the Physical Restraints Policy, including the fact that a one-piece garment that opens in the back is considered a restraint. On 1/19/24 DON educated nursing home team at huddle to discontinue use of Onesie. On 1/30/24 resident 27's care plan was updated to remove intervention "to utilize adaptive clothing when needed to prevent public disrobing". On 1/30/24 confirmation of removal of Onesie garments from resident's room by DON. On 2/6/24 the DON and MDS nurse acknowledge and understand that in the case that a restraint may be indicated the facility must ensure all appropriate documentation, including but not limited to the following:	2/15/24

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F 604	Continued From page 4 and policy review, the provider failed to ensure one of one sampled resident (27) was dressed in a Onesie (one-piece close-fitting garment with an opening in the back) restraint to prevent her from removing her clothing had the following: *Approval of the use of the Onesie restraint from resident 27's guardian. *An assessment to ensure the Onesie restraint was not used for staff convenience. *A physician's order for the use of the restraint. *Used the least restrictive restraint for the least amount of time. *Documented the use of the restraint in the care plan. *A routine re-evaluation to ensure the Onesie was appropriate and necessary. Findings include: 1. Observations of resident 27 revealed on: *On 1/16/24 at 5:30 p.m. she was wearing a flowered flannel Onesie with a zipper in the back. *On 1/17/24 at 10:30 a.m. she was wearing a denim Onesie with a zipper in the back. She continued to have that Onesie on through 4:30 p.m. *On 1/18/24 at 12:30 p.m. she was wearing a Onesie with a zipper in the back. Interview on 1/17/24 at 10:30 a.m. with resident 27's husband, who resided in the facility, revealed he was aware of the Onesie she wore. He stated she would remove her personal clothing if she wore regular clothing. Interview on 1/18/24 at 9:30 a.m. with certified nursing assistant (CNA) L regarding resident 27 revealed: *She wore the Onesie at all times otherwise she would remove her personal clothing,	F 604	*approval of the use of the restraint from resident or resident representative, *assessment done to ensure that the restraint is not being used for staff convenience *physician order for use of the restraint *use of the least restrictive restraint for the least amount of time *documentation of use of restraint in resident care plan *a routine re-evaluation to ensure the restraint is appropriate and necessary By 2/6/24 Assistant Administrator reviewed and educated DON B, MDS C, CNA L on FRHS Physical Restraint Policy including that FRHS is free of physical restraints, the definition of physical restraints, and that a Onesie is considered a physical restraint and will not be used at FRHS. On 2/9/24 all direct care staff including DON B, MDS C, CNA L received education titled "Freeman Regional Nursing Home Survey Education-2024" which includes FRHS Physical Restraint Policy including that a Onesie is considered a restraint and will not be used at FRHS **from Assistant Administrator.** Education and attestation of completion and understanding is to be completed by 2/15/24. All employees on prn or on leave of absence status will complete this education prior to their return to work. Beginning on 2/12/24, Assistant Administrator and/or designee will perform a Restraint Free Onesie Observation audit weekly for 8 weeks to ensure that resident 27 and all other residents will remain free from physical restraints. Assistant Administrator and/or designee will report the results of the audit to the QAPI committee weekly. The QAPI committee will direct further audits.	

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F 604	Continued From page 5 *As her dementia had progressed she started to remove her personal clothing. *She had been unable to be redirected when she took her clothing off. Interview on 1/18/24 at 2:30 p.m. with director of nursing B and Minimum Data Set coordinator C revealed: *They had not thought of the Onesie as a restraint. *Agreed there had been no assessments on the use of the Onesie. *They agreed it could have been a restraint as she had no access to her own body. Review of resident 27's undated care plan revealed: *Focus: "[Resident] has a hx [history] of disrobing and aggressive behaviors towards others at times." *Goal: "[Resident] will maintain current level of function through the next review date." The date was not listed. *Interventions: "INDIVIDUALIZED STAFF APPROACHES: -utilize adaptive clothing when needed to prevent public disrobing." Review of resident 27's electronic and paper medical records revealed no assessments were completed to determine if the Onesie was needed as a restraint. Review of the provider's last revised September 1993 Physical Restraints policy revealed: *"Physical restraints are defined as "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot	F 604		

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F 604	Continued From page 6 remove easily which restricts freedom of movement or normal access to one's body." *The provider will evaluate each resident for safety and provide adequate supervision and assistive devices to prevent avoidable accidents. *There was no guidance on what process was to have been completed to rule out a device as a restraint.	F 604		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) event report review, medical record review, physical therapy evaluation review, care plan review, interview, and policy review, the provider failed to ensure one of one certified nursing assistant (CNA) (I) had followed one of one sampled resident's (7) care plan for using two staff persons to transfer resident 7 using a Sara Plus stand lift, resulting in a fall and a fractured hip. Findings include: 1. Review of the SD DOH event report received on 12/28/23 from the provider revealed at 12/19/23 at 7:30 p.m.: *Resident 7 was being transferred with the use of a Sara Plus stand lift from a wheelchair to his bed	F 689	The facility will ensure that CNA I and all other direct care staff will follow resident 7's and all other residents' care plans related to the mechanical lifts and number of persons required to ensure safe transfers. On 1/19/2024 DON educated all nursing staff that all residents requiring a stand lift are to be assisted by two persons until further PT evaluation is completed. On 2/7/24 Physical Therapist evaluated resident 7 and all residents utilizing stand lifts, including the Sara Plus stand lift, to determine appropriate use of the mechanical lifts as well as the required number of staff to assist with the transfers. On 2/7/24 DON updated careplans of resident 7 and all residents utilizing stand lifts, including the Sara Plus stand lift, with the recommendations provided by the physical therapist for the use of the mechanical lifts as well as the required number of staff to assist with the transfers. On 2/7/24 the Administrator, Assistant Administrator, DON, and interdisciplinary team in collaboration with the medical director reviewed and retired the Stand Lift Therapy Equipment Policy and Procedure and adopted the Mechanical Lifts Policy and Procedure. The Mechanical Lifts Policy includes the use of mechanical lifts and the	2/15/24

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F 689	Continued From page 7 by CNA I when "He slipped out of the lift." -CNA I had been supporting his upper body as he fell to the floor. *The lift had been removed from use, inspected by the physical therapist (PT), and found no fault in the lift. -The lift sling was new and in good repair. *Registered nurse (RN) L assessed resident 7 after the fall and transferred him to the hospital where he was diagnosed with a fractured hip requiring a total hip replacement. *The provider report indicated CNA I had followed the policy for using the Sara Plus stand lift because CNA I was eighteen years old or older so she could "run a lift." Continued review of resident 7's 12/19/23 SD DOH event report revealed: *Director of Nursing (DON) B interviewed CNA I on 12/20/23 regarding resident 7's fall on 12/19/23 before her next scheduled shift revealed: *CNA I had confirmed: -She was using the Sara Plus stand lift independently on resident 7 at the time of his fall. -Resident 7 was in the Sara Plus stand lift, lifting him up to a standing position. -CNA I was standing behind him while cleaning his buttocks. -CNA I attempted to catch his fall by holding the top part of his body while protecting his head. *Review of RN L documentation confirmed his position when she entered his room. *A root cause analysis of the event completed by DON B, RN quality director P, Assistant administrator for senior living O noted that CNA I had not worked at the facility for several months because she had begun college in the fall of 2023..	F 689	number of staff required to assist "will depend on the resident's physical ability as evaluated by physical therapy personnel and/or a licensed nurse. CNAs are not able to determine the number of employees required to assist with the mechanical lift". Policy includes nursing personnel will receive training on mechanical lift use upon hire and annually thereafter and more often should need for education arise. The Mechanical Lifts Procedure refers to the lifts' instruction manuals. On 2/9/24 CNA I and all other unlicensed staff (CNAs) and licensed nurses began education on Mechanical Lifts Policy and Procedure including their role and responsibility for the safe and effective utilization of mechanical conveyances in the provision of resident care **from Assistant Administrator** and competency skills checklists for all mechanical stand lifts and full body lifts currently in use **from DON and/or designee**. Education and attestation of completion and understanding and competency skills checklists will be completed by 2/15/24. All employees on prn or on leave of absence status will complete this education prior to their return to work. On 2/9/24 CNA I and all other unlicensed staff (CNAs) and licensed nurses began education on the expectation to review the Care Plan Kardex at the beginning of each shift and write transfer requirements on daily assignment sheets **from Assistant Administrator.** Each resident's Care Plan Kardex includes day-to-day aspects of the ADL and care needs, specifically Resident 7's and all other residents' mobility and transfer requirements and the number of employees required when assisting a resident with a mechanical lift. Education and attestation of completion and understanding will be	

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F 689	Continued From page 8 -She had not looked through the care plans before she stepped onto the unit to provide care for the residents she was assigned to on 12/19/23. 2. Review of resident 7's medical record revealed: *One 10/16/23 at 2:00 a.m. he was discovered on the floor beside his bed. -He had told a staff member he was attempting to retrieve his socks and shoes. *On 10/16/23 at 2:18 p.m. he was evaluated by a physician to check his injuries. *One 10/23/23 at 2:00 p.m. a nursing progress note indicated Minimum Data Set (MDS) coordinator/RN C and licensed social worker M had discussed his pain and that he had increased pain since that fall, requiring the use of a full-body mechanical lift. *He had a history of multiple sclerosis (MS), foot drop, and multiple falls, and was identified as a fall risk. *A 10/27/23 PT evaluation indicated PT N had encouraged charge nurses and CNAs to continue using the full-body mechanical lift. *A 10/30/23 PT evaluation indicated PT N recommended resident 7 to progress to the Sara Plus stand lift to help progress his lower extremity strength and tolerance. PT N educated the RN and CNA staff of the recommended changes. 3. Review of resident 7's care plan with a start date of 11/7/23, revealed: *For toileting he was to have had total assistance of two staff persons to transfer him with a full-body lift on and off the commode (toilet). *For transfers he was to have had two staff persons for using the Sara Plus stand lift.	F 689	completed by 2/15/24. All employees on prn or on leave of absence status will complete this education prior to their return to work. Beginning February 12th, Assistant Administrator and/or designee will perform 5 (five) Care Plan Kardex to Assignment Sheet audits weekly for 8 weeks to ensure that caregivers will follow resident 7's and all other residents' care plans related to the equipment and number of persons required to ensure safe transfers. Assistant Administrator and/or designee will report the results of the audits to the QAPI committee weekly. The QAPI committee will direct further audits. Beginning February 12th, Assistant Administrator and/or designee will perform 3 (three) transfer observation audits weekly for 8 weeks to ensure that caregivers will follow resident 7's and all other residents' care plans related to the equipment and number of persons required to ensure safe transfers. Assistant Administrator and/or designee will report the results of the audits to the QAPI committee weekly. The QAPI committee will direct further audits.	

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F 689	Continued From page 9 4. Interview on 1/18/24 at 10:30 a.m. with DON B and MDS coordinator/RN C regarding resident 7's 12/19/23 fall revealed: *After a period of not working, CNA I had not reviewed the resident care plans before providing care for them on 12/19/23. *Resident 7 had been declining both physically and cognitively for the last several months. -He was care planned for two staff persons with him for all mechanical lift transfers. *When asked about a care plan specific for CNA's to use so they could carry it with them to refer to, MDS coordinator C stated she had provided a daily assignment sheet specific for each CNA to carry while working. -Resident 7's 12/19/23 daily assignment sheet provided to this surveyor had stated that he was supposed to use two staff members while using a stand lift. *DON B stated staff education was provided by her after the incident, including CNA I and all of the nursing staff. -She stated she had not kept the information provided to those staff members or a record of the attendance of the staff. *Observation at the same time, of the Sara Plus stand lift revealed: -MDS coordinator C was placed in the lift so that this surveyor could visualize how it worked. -A sling was placed on the person's abdomen and closed using the Velcro belt on the sling. -DON B stated the assessment after the 12/19/23 fall had determined: --The sling had been attached to the lift correctly and was tight enough to prevent him from falling through the sling. --The sling was still attached to the lift even after resident 7 fell. --CNA I stated in the SD DOH event report his	F 689		

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 01/18/2024

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 689	Continued From page 10	F 689		

legs just "crumbled" beneath him as he fell straight down.

5. Review of the provider's January 2024 Stand Lift Therapy Equipment Policy and Procedure revealed:
*The policy for the lift was to be recommended for residents deemed appropriate by licensed PT's, in collaboration with PT assistants and nursing services.
*All facility staff involved in resident care would have been assigned responsibility for ensuring compliance with the policy.
*If variance from a care plan was necessary, the DON or PT staff would have been consulted.
*Staff members would be provided with training initially and as needed to correct improper use or understanding of safe resident handling.
*Use of the stand lift required manual operation of one staff member.
*Staff is required to maintain direct line of sight supervision with all residents utilizing a stand lift.
*Residents would have been required to maintain upright posture, and maintain satisfactory level of safety.

Review of the undated Sara Plus Instructions For Use revealed the Sara Plus stand lift was to always be handled by a trained caregiver, continuously attending to the resident.

Review of the provider's November 2021 Falls and Accidents policy revealed:
*The determination of supervision was based on the resident's assessed needs and identified hazards in the residents environment.
*All staff would have been educated about and have access to care plans which were initialized for each resident and address potential hazards.

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 01/18/2024

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 689	Continued From page 11 *Effective and modification of interventions was monitored on a regular basis through QAPI (Quality assurance and performance improvement) program. *The residents care plan would specifically address any risk factors that provided a benefit, such as a mobility device.	F 689		

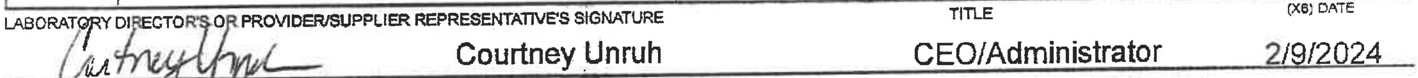
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435112	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	01/17/2024

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

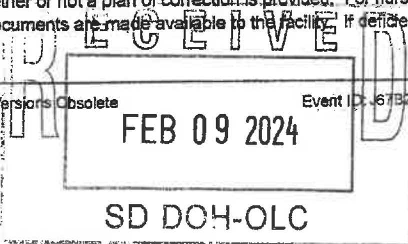
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/17/24. Oakview Terrace was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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



Courtney Unruh | CEO/Administrator | 2/9/2024

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.



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

PRINTED: 01/31/2024
FORM APPROVED
OMB NO. 0938-0391

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 ______	01/18/2024

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
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 1/16/24 through 1/18/24. Oakview Terrace was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Courtney Unruh	CEO/Administrator	2/9/2024

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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FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10621	A. BUILDING: ______ B. WING ______	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	510 E 8TH ST POST OFFICE BOX 370 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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/16/24 through 1/18/24. Oakview Terrace was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/16/24 through 1/18/24. Oakview Terrace was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Courtney Unruh	CEO/Administrator	2/9/2024

STATE FORM 6899 3PW611 If continuation sheet 1 of 1