STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435112	A. BUILDING B. WING	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	510 E 8TH ST POST OFFICE BOX 370, FREEMAN, South Dakota, 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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/18/26 through 8/20/26. Oakview Terrace was found not in compliance with the following requirements: F609, F689, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/18/26 through 8/20/26. The areas surveyed was regarding timely reporting of a resident's unexpected death and elopements from the facility. Oakview Terrace was found not in compliance with the following requirements: F609, and F689.	F0000		
F0689 SS = E	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 observation, interview, record review, and policy review, the provider failed to ensure a safe environment and supervision for one of one sampled resident (15), identified at risk for falling and with a fall prevention intervention that directed staff to not leave him in his wheelchair alone in his room, who fell from his wheelchair and sustained bruising and a laceration (a deep cut) above his left eyebrow when he was left in his room and his wheelchair alone by nursing staff.	F0689	The facility will ensure that CNA K, CNA J, CNA S, RN F, DON B, and all other direct care employees (CNA G no longer an employee) will follow resident 14's and resident 10's (Resident 39 is no longer a current resident) care plans and ensure the safety and supervision and a safe environment and adequate supervision for those at risk of falling and elopement. On 9/7/2026, Administrator and Assistant Administrator reviewed Resident 15's care plan and no changes were made. On 9/7/2026, Administrator and Assistant Administrator reviewed Resident 10's care plan and no changes were made. Resident 39's care was not able to be reviewed as she is no longer a resident. On 9/10/2026, Director of Nursing checked Resident 15's and all other resident's wheelchairs to ensure all wheelchair cushions in use were secured appropriately. On 9/9/2026, Administrator and Assistant Administrator reviewed and retired the Elopement Risk Evaluation v2.0 and adopted the Elopement Risk Screening noting residents' status in areas including mobility, mental status, emotional status, history of elopement attempts, behavior management, medications, and diagnoses as well as potential interventions. On 9/9/2026, Administrator and Assistant Administrator reviewed and retired the Elopement Risk Evaluation v2.0 and adopted the Elopement Risk Screening noting residents' status in areas including mobility, mental status, emotional status, history of elopement attempts, behavior management,	9/30/26

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Courtney Hind	CEO/Administrator	9/11/26

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F0689 SS = E	Continued from page 1 Findings include: 1. Observation and interview on 8/18/26 at 9:55 a.m. with resident 15 in his room revealed he was sitting in a recliner with his wheelchair folded up and tucked behind the bedroom door. He had a bruise under his left eye and steri-strips (thin, adhesive strips used to hold the edges of a cut or wound together as it heals) over his left eyebrow. He said that about a week ago in his room, he reached for something and fell out of his wheelchair, landed on his stomach, and bumped his face on the floor, which resulted in a bruised eye and lacerated eyebrow. 2. Review of resident 15's electronic medical record (EMR) revealed he admitted to the facility on 4/30/26. His diagnoses included nontraumatic intracerebral hemorrhage (a sudden bleed inside the brain tissue, commonly referred to as a stroke, caused by a medical condition rather than an injury or accident), and polyneuropathy (a medical condition where multiple peripheral nerves throughout the body malfunction at the same time, causing numbness, tingling, burning pain, and muscle weakness). His 8/3/26 Brief Interview for Mental Status assessment score was 10, which indicated his cognition was moderately impaired. Resident 15's fall risk assessment scores on 5/4/26 and 8/3/26 were both 75, which indicated he had a high risk for falling. His 5/1/26 care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) indicated he "tends to be impulsive" and should be supervised while in his wheelchair. Progress notes in resident 15's EMR indicated that in addition to the fall he recalled on 8/8/26, he fell four more times since his admission to the facility, none of which required outside medical treatment. On 5/5/26, a progress note revealed resident 15 fell out of his wheelchair in the south television lounge and sustained a goose egg (a raised, swollen lump that forms on the head after a blunt impact), a small laceration to the right side of his forehead, and a small skin tear to his right upper forearm above his elbow. The intervention implemented to prevent subsequent falls was "more frequent/closer monitoring."	F0689	medications, and diagnoses as well as potential interventions. By 9/15/2026, MDS RN or designee will update Resident 10's and all other residents' Elopement Risk Screenings and all care plans with new Elopement Risk results. On 9/7/2026, Administrator and Assistant Administrator reviewed the Baseline/Comprehensive Care Plans LTC Division Policy including: • "The interdisciplinary team will develop a...care plan for each resident....to provide effective and person-centered care of the resident that meet profession standards of quality care and to attain or maintain the resident's highest practicable, physical, mental and psychosocial well-being." • will include "Interventions - actions, treatments, procedures, or activities designed to meet an objective," • will "address resident and safety concerns to prevent decline or injury," • "A comprehensive care plan will be developed...by the interdisciplinary team, composed of individuals who have knowledge of the resident and his/her needs, and that each resident and/or representative is involved in developing the care plan and making decisions about his or her care." On 9/9/2026, Administrator and Assistant Administrator reviewed the LTC Falls and Accidents policy, including: • "All staff will be educated about and have access to care plans which are individualized for each resident and address the potential hazards." On 9/10/2026, Administrator and Assistant Administrator reviewed and updated the Elopement policy, including: • "Elopement [is defined as] when a resident leaves the premises or a safe area unnoticed without authorization / supervision. • "At admission/readmission, quarterly, with status changes, and with notable at risk behaviors, assess resident for tendency to wander and/or actual history of wandering/elopement within the past year. • "If no resident or person was observed setting off the alarm and no resident/person is visualized outside the nursing home: o a. Notify charge nurse, & o b. Account for all residents and document that all residents were accounted for. • "When resident returns to facility: o a. Assess physical condition (e.g., any injuries, etc.). o b. Reassure of well-being/validate feelings. o C. Add risk to care plan. By 9/18/2026, Assistant Administrator or designee will review and provide education to CNA K on the Elopement policy including "If no resident or person was observed setting off the alarm and no resident/person is visualized outside the nursing home: a. Notify charge nurse, & b. Account for all residents and document that all residents were accounted for." By 9/18/2026, Assistant Administrator or designee will review and provide education to RN F how to access Care Plans in	

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F0689 SS = E	Continued from page 2 On 5/17/26, a progress note indicated resident 15 fell on the floor in front of his recliner in his room while trying to reach his TV remote. No injuries or interventions were documented. On 5/27/26, a progress note revealed resident 15's wheelchair cushion was not secured to his wheelchair and he slid out of his wheelchair while trying to turn off the television (TV) in his room, which resulted in a ping pong-sized hematoma (a localized collection of clotted or partially clotted blood outside of the blood vessels, caused by damage to an artery, vein, or capillary) to the right side of his forehead with a small cut in the middle. The intervention implemented to prevent subsequent falls was "Resident is not to be left alone in his room while in [his] wheelchair. Make sure the [wheelchair] cushion is secured to the wheelchair." On 6/3/26, a progress note indicated resident 15 did not realize his call light was attached to his shirt. He attempted to get out of bed to get something without waiting for the staff's assistance and rolled out of bed and onto the floor, but did not sustain any injuries. The intervention implemented to prevent subsequent falls was to "[lower the] bed to [the] floor, reminded resident to use call light." An 8/8/26 progress note revealed resident 15's most recent fall resulted in two 1-centimeter (cm) lacerations to his left eyebrow and a 1.2 cm by 1.6 cm skin tear and a hematoma to his left elbow. 3. Observation on 8/20/26 at 8:45 a.m. revealed resident 15 sitting in his wheelchair by a puzzle table in the south lounge area, near other residents being monitored by the staff. He remained there until 9:35 a.m., when activities assistant V wheeled him away to attend devotions in the dining room. 4. Interview on 8/20/26 at 8:55 a.m. with certified nursing assistant (CNA) K revealed that she knew resident 15 had a high risk for falling. To prevent him from falling in his room, the staff were to keep him out of his room when he was in his wheelchair so he did not try to get into his recliner or bed without the staff's assistance. They took him to the south lounge area to work on a puzzle or listen to music "to keep a better eye on him." She said	F0689	the EMR, location of individualized resident-centered fall interventions on the Care Plan, and the Fall & Accident Prevention policy. By 9/18/2026, Assistant Administrator or designee will review and provide education with CNA S, on the Elopement policy including "If no resident or person was observed setting off the alarm and no resident/person is visualized outside the nursing home: a. Notify charge nurse, & b. Account for all residents and document that all residents were accounted for." By 9/18/2026, Assistant Administrator or designee will review and provide education to DON B the Elopement policy including "If no resident or person was observed setting off the alarm and no resident/person is visualized outside the nursing home: a. Notify charge nurse, & b. Account for all residents and document that all residents were accounted for." No education will be provided to CNA G as CNA G is no longer employed at this facility. By 9/18/2026, all nurses, including RN F and DON B, will receive education including the Elopement policy, that when resident returns to the resident's physical condition needs to be assessed and the risk of elopement needs to be added to the care plan. Education and attestation of completion and understanding is to be completed by 9/30/2026. All employees on prn or on leave of absence status will complete this education prior to their return to work. By 9/18/2026, all direct care staff, including CNA K, CNA J, CNA S, (CNA G no longer employed at this facility), RN F , and DON B, will receive education including the Elopement policy, that if no resident or person was observed setting off the alarm and no resident/person is visualized outside the nursing home employees are to notify charge nurse, account for all residents and document that all residents were accounted for, the Falls and Accidents LTC Division Policy, how to access Care Plans in the EMR, and where to access individualized resident-centered fall interventions and elopement risk on the Care Plan. Education and attestation of completion and understanding is to be completed by 9/30/2026. All employees on prn or on leave of absence status will complete this education prior to their return to work. Beginning 9/14/2026, Director of Nursing or designee will perform four Adaptive Equipment Cleaning and Intactness Observation audits weekly to ensure Resident 15's and all other resident's adaptive equipment including wheelchair seat cushions are utilized appropriately. Assistant Administrator will report the results of the audits to the QAPI Committee weekly. The QAPI committee will direct further audits. Beginning 9/14/2026, Director of Nursing or designee will perform weekly Adaptative Equipment Cleaning & Intactness Documentation audits to ensure that resident 15's and all other residents' adaptive equipment documentation is completed, including that seat cushions are utilized appropriately. Assistant Administrator will report the results of the audits to the QAPI Committee weekly. The QAPI committee will direct further audits.	

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F0689 SS = E	Continued from page 3 resident 15 knew he was not supposed to be alone in his room when he was in his wheelchair. 5. Interview on 8/20/26 at 9:10 a.m. with registered nurse (RN) F revealed she did not know whether any specific fall interventions were listed in resident 15's care plan, but she knew general interventions the staff used to prevent every resident from falling. "We just check on him frequently and make sure his call light is within reach." She was not aware that specific interventions to prevent resident 15 from falling included making sure he was not in his wheelchair while in his room. 6. Interview on 8/20/26 at 9:41 a.m. with CNA J revealed that when resident 15 was in his room, "he's supposed to be in his recliner, not his wheelchair." 7. Interview on 8/20/26 at 9:49 a.m. with director of nursing (DON) B revealed that while resident 15 knew he should not be in his wheelchair in his room alone, she said he could propel himself in his wheelchair to his room before the staff could assist him into his recliner. "I don't believe [the] staff deliberately left him in his room alone," she said, and added that it was unacceptable that the staff left him alone in his room where he fell, since the intervention was noted. She considered every resident to be at risk for falling, and those who had an extreme risk had interventions in their care plan. Any updates regarding care plans or resident fall interventions were discussed among the staff during shift report and daily huddle (leadership team) meetings. She expected the charge nurses to ensure that the CNAs were following the residents' care plans. 8. Interview on 8/20/26 at 11:17 a.m. with administrator A revealed that she expected all staff to follow the residents' care plans. "If the intervention was that we shouldn't leave him in his wheelchair alone, then we weren't following [his] care plan." 9. Review of the provider's July 2026 Baseline/Comprehensive Care Plans LTC [Long Term Care] Division Policy revealed the resident's comprehensive care plan was developed by an interdisciplinary team upon admission to the facility and updated quarterly and with a change in	F0689	Beginning 9/14/2026, Director of Nursing or designee will perform four Door Alarm audits monthly to ensure that staff are responding to door alarms as indicated in FRHS Elopement policy including accounting for all residents if no one was observed setting off the alarm and no resident/person is visualized outside the nursing home. Assistant Administrator will report the result of the audit to the QAPI committee weekly. The QAPI committee will direct further audits. Beginning 9/14/2026, Director of Nursing or designee will perform four Care Plan Safety Observational Audits per week to ensure staff are providing adequate supervision per the resident's individualized care plans, including fall and elopement risk interventions. Assistant Administrator will report the results of the audit to the QAPI committee weekly. The QAPI committee will direct further audits. Beginning 9/14/2026, Assistant Administrator or designee will perform an Elopement Risk Screening documentation audit for all residents including Resident 10 and Resident 15 quarterly and with any notable at risk behaviors to ensure completion of Risk Assessment per Elopement policy. Assistant Administrator will report the results of the audit to the QAPI committee weekly. The QAPI committee will direct further audits.	

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F0689 SS = E	Continued from page 4 condition. It should address the resident and their safety concerns to prevent decline or injury and include interventions (actions, treatment, procedures, or activities designed to meet an objective) to help the resident attain or maintain their highest practicable physical, mental, and psychosocial well-being. 10. Review of the provider's April 2026 Falls and Accidents LTC Division Policy revealed that all staff were educated and have access to care plans, which were individualized for each resident and address potential hazards. B. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to ensure the safety and supervision of two of two sampled residents (10 and 39) left the nursing home without the staff's knowledge (eloped) and entered the adjoining hospital. Findings include: 1. Review of the provider's 2/21/26 SD DOH report regarding resident 39's elopement revealed that on 2/21/26 at 8:10 p.m., the CNAs heard the nurses' station door alarm sound and responded to that alarm. They did not see any residents outside of that door. A different resident was in front of the door, and staff assisted the resident to a safe area. Resident 39 had received staff assistance at approximately 7:00 p.m. in her room. The hospital staff brought resident 39 back from the hospital at approximately 8:23 p.m. Resident 39 did not display any distress upon return to the nursing home. The RN was informed of that incident after the resident returned from the hospital but did not assess the resident. The staff assisted resident 39 with personal cares and put the resident to bed. 2. Interview on 8/20/26 at 12:15 p.m. with certified nursing assistant (CNA) S revealed she worked the day shift on 2/21/26 when resident 39 left the nursing home. She remembered assisting the resident that day, but she did not see the resident leave her room or the nursing home. She had heard the door alarm while she was providing care to another resident. She had looked out the nurses'	F0689		

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F0689 SS = E	Continued from page 5 station entrance door adjoining the nursing home and hospital, but did not see the resident. CNA S did not remember checking that all residents were accounted for after the door alarm had alarmed. Another resident was by the nurses' station entrance door, and she thought that resident had triggered that door alarm. The hospital staff brought resident 39 back to the nursing home, and the resident did not appear in distress and acted like her normal self. 3. Interview on 8/20/26 at 12:25 p.m. with DON B revealed that their camera footage was only available for seven days. The direct care staff did not have access to camera footage to check on the residents. She stated that by the time the hospital staff had brought back resident 39, and the nursing home staff realized the resident was not in her room, there was not enough time to do a head count on the residents. 4. Review of resident 39's record revealed she was admitted to the facility on 12/3/24. Her care plan indicated she ambulated with assistance of one staff member with her walker, but for long distances she utilized a wheelchair and could self-propel. She was at risk for elopement and wandered at times related to being disoriented to place, and had impaired safety awareness and confusion related to dementia (a group of symptoms affecting memory, thinking, and social abilities). Her 12/3/24 elopement risk evaluation indicated she was not at risk for elopement. The staff was to distract her from wandering by offering diversions, structured activities, food, conversation, or television. 5. Following resident 39's elopement on 2/21/26, all staff were reeducated about the facility's elopement policy and procedure and that the time the door would alarm was shortened. The nurse assessment following resident 39's elopement was requested but was not provided by the end of the survey. 6. Review of the provider's 6/26/26 SD DOH FRI regarding resident 10 revealed that at 3:45 p.m. on 6/26/26, resident 10 was sitting in a chair by the nurse's station and the main entrance of the	F0689		

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F0689 SS = E	Continued from page 6 nursing home, which opened to an enclosed corridor that connected the nursing home to the hospital. Resident 10 had gotten out of the chair, exited the main door of the nursing home, and silenced the door alarm by pressing a bypass button next to the main entrance door. CNAs G and K heard the alarm before resident 10 silenced it, came to the main entrance door, and noticed that resident 10 was no longer seated near the nurse's station. Video surveillance showed that approximately 90 seconds after the door alarm sounded, CNAs G and K located resident 10 sitting in a chair in the enclosed corridor outside of the main entrance of the nursing home. They transferred him to his wheelchair and brought him back into the nursing home. RN F assessed resident 10 and found that his vital signs were all within normal limits. He had no injuries, pain, or discomfort. His physician and family member were notified of the incident. The elopement policy did not change between February and resident 10's 6/26/26 elopement, so assistant administrator D did not feel the staff needed to be reeducated on the policy in June. The staff hired between February and June received new employee orientation that covered emergency preparedness, wandering, and elopements, and were trained by existing CNAs to learn each resident's unique needs. Elopement drills were held following resident 10's 6/26/26 elopement, with opportunities identified for the staff to ensure that all current residents were accounted for after a door alarm sounded. Minimum data set (MDS) specialist/infection preventionist H reviewed elopement assessments for all current residents, and for those who identified as an elopement risk, she reviewed their assessments and care plans for accuracy. The facility's Care Plan policy was updated to include the results of the resident's elopement assessment. All residents' care plans were audited to ensure that they included the elopement assessment results, and ongoing audits are scheduled quarterly through the end of 2026. All audits were discussed at the facility's 7/13/26 Quality Assurance and Performance Improvement (QAPI) meeting. 7. Review of resident 10's electronic medical record (EMR) revealed he admitted to the facility on 11/17/23. His diagnoses included unspecified	F0689		

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F0689 SS = E	Continued from page 7 psychosis (a state of losing touch with reality), dementia (a group of symptoms affecting memory, thinking, and social abilities), and neurosyphilis (when syphilis bacteria attack the brain and nervous system, causing delirium, mania, hallucinations, psychosis, and dementia). He had a 4/28/26 Brief Interview for Mental Status assessment score of 9, which indicated his cognition was moderately impaired. His 2/3/26 and 4/28/26 Elopement Risk Evaluations had scores of 3, which indicated he was at risk for eloping due to a history of wandering, attempting to leave the facility without informing the staff, and verbally expressing the desire to go home. Resident 10's progress notes indicated that the staff redirected him to his room or the nurse's station when he attempted to wander or leave the facility. An 8/18/25 progress revealed that resident 10 activated the door alarm when he opened the main entrance door of the nursing home at 4:30 a.m., and the staff redirected him back to his room. In January 2026 he moved to a room located closer to the nurse's station. His 5/5/26 care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) did not include any wandering or exit-seeking behaviors or any interventions related to those behaviors. His care plan indicated that he preferred to spend much of his day in his room reading his bible, watching television, and visiting with others. On 6/30/26, resident 10's care plan was updated to include his history of elopements "on days when he demonstrates increased impulsivity/confusion and is seeking interaction with others." His care plan interventions were updated to include, "Do not leave [resident 10] unattended when sitting at [the] nurse's station." Resident 10's care plan updated to include the results of his 2/3/26 and 4/28/26 Elopement Risk Evaluations, which indicated he was at risk for elopement due to a history of wandering, attempting to leave the facility without informing the staff, and verbally expressing a desire to go home. Resident 10's care plan updates were discussed at the staff huddle and shift report meetings from 7/1/26 through 7/8/26. On 7/29/26, the facility's interdisciplinary care team met and confirmed that resident 10 had made no additional attempts to exit the facility.	F0689		

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F0689 SS = E	Continued from page 8 8. Interview on 8/19/26 at 3:04 p.m. with CNA G revealed that resident care plan updates were passed along during the staff huddle and shift report meetings by leadership staff and the charge nurses and were reflected on the care plan and Kardex (a report of the resident's care needs and interventions). The residents' EMR indicated if they wandered or were at risk for elopement, and the CNAs were to document their behaviors each shift. When residents wandered, the staff tried to distract or redirect them with an activity or a snack. 9. Interview on 8/20/26 at 8:55 a.m. with CNA K regarding resident 10's elopement revealed that she assumed a visitor or family member had left the nursing home when resident 10 eloped and activated the door alarm on 6/26/26. Since then, the staff no longer would leave resident 10 alone at the nurse's station, and the daily huddle and shift report meetings included updates on resident care plans and the residents who wandered. 10. Interview on 8/20/26 at 9:10 a.m. with RN F revealed that resident care plans were discussed at daily huddle and shift report meetings, then placed in a notebook at the nurse's station for the staff to review throughout the following week. She recalled that on 6/26/26, resident 10 was "pretty antsy" and "probably just wanted a change in scenery." She said he frequently sat at the nurse's station to visit with the staff. 11. Interview on 8/20/26 at 9:49 a.m. with DON B revealed that all residents were to have an elopement assessment completed, and those who wandered or were at risk for eloping were to be discussed during the daily huddle and shift report meetings. She expected all nursing staff to familiarize themselves with all of the residents' care plans, which included individual interventions that helped prevent behaviors, including elopement. 12. Interview and record review on 8/20/26 at 10:10 a.m. with assistant administrator D revealed that following resident 10's elopement, director of facilities E disabled the bypass button next to the main entrance door, which previously allowed individuals to silence the door alarm after it sounded when the door was opened. Afte the bypass button was disabled, the staff had to enter a code on a keypad to turn off the door alarm. The staff placed a sign on the main entrance door that read, "If you	F0689		

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F0689 SS = E	Continued from page 9 inadvertently sound the alarm, please remain right here until a staff member is able to connect with you." On 7/6/26, the bypass button was replaced with a keypad entry system that required a code to deactivate the door alarm. All staff were reeducated to perform a full count of current residents if they were unable to identify who activated the alarm. 13. Interview on 8/20/26 at 11:17 a.m. with administrator A revealed she expected the staff to interact with the residents who were at risk for eloping. 14. Review of the provider's July 2026 Elopement Policy and Procedure defines elopement as "When a resident leaves the premises or a safe area unnoticed without the facility's knowledge and supervision or authorization," or when a resident "breaches the door or walks or moves over the threshold." The procedure specified that, "If no resident or person was observed setting off the alarm and no resident/person is visualized outside the nursing home: a. Notify the charge nurse, and b. account for all the residents and document that all residents were accounted for. 4. When a resident returns to the facility: a. Assess the resident's physical condition. b. Reassure of the resident's well-being/validate the resident's feelings."	F0689		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for	F0609	The facility will ensure that RN T, DON B, DON A, System DON B, and Administrator A as well as all nurses and administrators will report to the SD DOH within two hours all incidents that involve serious bodily injury from an unknown source. On 9/7/2026, Administrator and Assistant Administrator reviewed the Expired Patient, Care of, Coroner Case, Autopsy, Death Pronouncement policy including: • "the county coroner shall investigate any human death if a determination of the cause and manner of death is in the public interest. Deaths which are in the public interest, without limitation, are: A. All deaths by unnatural means or if there is a suspicion of unnatural means, including all deaths of accidental, homicidal, suicidal, and undetermined manner, regardless of suspected criminal involvement in the death" • Death Pronouncement: A. A Physician/Advanced Practice Practitioner(APP) is required to pronounce death. Pronouncing death is not within the scope of Registered/Licensed Practical Nursing Practice in the State of South Dakota. The Registered Nurse (RN)/Licensed Practical Nurse (LPN) may	9/30/26

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F0609 SS = D	Continued from page 10 jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to report a serious bodily injury from an unknown source to the SD DOH within two hours for one of one resident (38) when she was found with head trauma and deceased in her room by two of two certified nursing assistants (CNAs) (R and S). Findings include: 1. Review of the provider's 10/18/25 SD DOH FRI received at 4:40 a.m. revealed that on 10/18/25 resident 38 was found unresponsive on her bedroom floor at 1:50 a.m. with severe trauma to her head by CNAs R and S. Resident 38 had a do-not-resuscitate (DNR) (a medical directive stating that if a person's heart stops or they stop breathing, healthcare staff should not perform CPR or other resuscitation measures) code status. CNA R and S notified RN T, who determined the resident had no respirations or pulse. RN T and CNA U lifted resident 38 off the floor with a total body lift (a mechanical lift and sling used to lift a person's full body) and placed her in her bed. CNA R and S last saw the resident at 10:00 p.m. to assist her with getting ready for bed and left her sitting in her recliner watching television (TV). Resident 38 was independent in her room, and she did not activate her call light for staff assistance. Resident 38 was wearing gripper (non-skid) socks. The lights and TV were on in the room. Her electric recliner was in a high position. The call light was on the right arm of her recliner, and her walker was positioned to the left side of the recliner, against the wall between the TV stands. The door was opened slightly. RN T called director of nursing (DON) B at 2:03 a.m.	F0609	act as a Physician Agent in pronouncing death using the following approved criteria and procedure. B. RN/LPN will assess the patient and document the following criteria in the Nurses Notes: i. No auscultated apical heart tones or palpable carotid pulse x 1 min. ii. No voluntary respirations or auscultated breath sounds x 1 min. iii. Fixed, dilated pupils. iv. Unresponsive to verbal or painful stimuli. C. The RN/LPN will notify the on-call Physician/APP of the above clinical findings. D. The attending provider may consider RN/LPN's assessments and observations and may pronounce a patient's death without actually seeing the body or being physically present at the site of death. The provider may then issue a telephone order to pronounce death. E. The RN/LPN will enter a physician order for death pronouncement, enter the date and time of death pronouncement. By 9/14/2026, Director of Quality or designee will update the FRHS Safety Incident Report to include prompts for employees to notify the Director of Nursing, Administrator, and SD Department of Health in addition to the existing notification prompts. By 9/11/2026, Assistant Administrator or designee will update the EMR Death Progress Note template to include from the Expired Patient, Care of, Coroner Case, Autopsy, Death Pronouncement policy the specific criteria required to be assessed by the RN/LPN at the time of a resident's death as well as the criteria being shared with the physician and the physician's response. Criteria from policy includes: • Any auscultated apical heart tones or palpated carotid pulse noted (check for 1 minute)? Y/N • Any voluntary respirations or auscultated breath sounds noted (checked for 1 minute)? Y/N • Pupils fixed and dilated? Y/N • Any response to verbal or painful stimuli? Y/N • What information was given to the provider? • Was pronouncement of death order given by provider? (Y/N) • Was telephone order process completed? (Y/N) On 9/7/2026, Administrator and Assistant Administrator reviewed the Abuse, Neglect, Mistreatment & Misappropriation of Resident Property LTC Division Policy including: • "All alleged violations of abuse, neglect, exploitation of residents, misappropriation of resident property, injuries of unknown origin, corporal punishment, and involuntary seclusion must also be reported by the facility to officials in accordance with State law, including to the State	

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F0609 SS = D	Continued from page 11 to inform her of the incident and requested directions due to the unusual nature of the event. DON B called system DON O at 2:10 a.m. to prepare to go into the facility to support the staff. Resident 38's family member was called at 2:15 a.m., and DON B called administrator A at 2:18 a.m. DON B and administrator A determined that they did not need to notify the coroner. DON B notified RN T that the coroner did not need to be notified and that resident 38 could be moved to her bed and be provided with postmortem (after death) care. RN T documented in the progress note that she notified the on-call doctor, medical doctor P, at 3:39 a.m. 2. Review of resident 38's electronic medical record (EMR) revealed she admitted to the facility on 12/23/24. Her 8/5/25 Brief Interview for Mental Status (BIMS) evaluation score was 9, which indicated her cognition was moderately impaired. Her diagnoses included unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities), type 2 diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar), polyneuropathy (a symmetric peripheral nerve disorder resulting in varying degrees of sensory loss, pain, and weakness), and atrial flutter (an abnormal rapid and regular heart rhythm). Her 10/20/25 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated that she was independent with repositioning herself in bed, eating, drinking, oral care, personal hygiene, transfers, going to the bathroom during the day, and using a bedside commode at night. She was independent with her walker in her room and wore incontinence (involuntary urine or bowel leakage) supplies. She required one staff member to assist with dressing, undressing, and propelling in her wheelchair outside of her room. She did not wear shoes, only gripper socks. Her 8/5/25 Morse Fall Scale (a tool used in healthcare to estimate a patient's risk of falling by scoring factors like history of falls, gait, and use of assistive devices) assessment score was 90, indicating she was at high risk for falling. Her 10/18/25 progress note indicated that resident 38 did not have respirations or a pulse and had severe facial trauma after her fall. RN T called resident 38's family member at 2:15 a.m., then called the funeral home at 2:58 a.m. and at 3:23 a.m., and then called medical doctor P at 3:39 a.m. The progress note did not indicate what information medical doctor P provided to the facility to	F0609	Survey Agency and adult protective services where state law provides for jurisdiction in longterm care facilities. o Immediately, but no later than 2 hours if the alleged violation involves abuse or results in serious bodily injury." o Visual safety rounding does not require waking the resident every two hours. Staff can quietly verify that a resident resting with eyes closed appears safe, is appropriately positioned, and the environment is safe. Toileting, repositioning, continence care, etc. according to the resident's individual needs and care plan will be provided in addition to the safety check." By 9/14/2026, System Director of Nursing or designee will implement updated safety rounds documentation for visual observations of residents for safety at least every two hours during the night. By 9/18/2026, Assistant Administrator or designee will review and provide education to CNA U on the need to contact the coroner prior to moving the body of deceased resident and the Expired Patient, Care of, Coroner Case, Autopsy, Death Pronouncement policy. By 9/18/2026, Assistant Administrator or designee will review and provide education to CNA J on the Abuse, Neglect, Mistreatment & Misappropriation of Resident Property LTC Division Policy, and the need to report to the SD Department of Health a serious bodily injury from an unknown source within two hours. By 9/18/2026, Assistant Administrator or designee will review and provide education to RN T on: • the Abuse, Neglect, Mistreatment & Misappropriation of Resident Property LTC Division Policy, • the need to report to the SD Department of Health a serious bodily injury from an unknown source within two hours, • the need to contact the coroner prior to moving the body of deceased resident, • the need to document what the nurse shares with the provider and what the provider shares to the nurse at the time of a resident's death, and • the Expired Patient, Care of, Coroner Case, Autopsy, Death Pronouncement policy. By 9/18/2026, Assistant Administrator or designee will review and provide education to DON B on: • the Abuse, Neglect, Mistreatment & Misappropriation of Resident Property LTC Division Policy, • the need to report to the SD Department of Health a serious bodily injury from an unknown source within two hours, • the need to contact the coroner prior to moving the body of deceased resident, • the Expired Patient, Care of, Coroner Case, Autopsy, Death Pronouncement policy.	

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F0609 SS = D	Continued from page 12 pronounce her death. 3. Interview on 8/19/26 at 9:20 a.m. with CNA R revealed that she worked the night shift on 10/18/25 and had assisted resident 38 with personal cares around 9:00 p.m. She passed fresh water to the residents around 3:00 a.m., and when she entered resident 38's room, she saw her lying in the middle of her room with blood around her face and head area. If the residents were independent, the staff would check on them at 3:00 a.m., when the staff passed out fresh water. If independent residents did not activate their call light, the staff did not check on them more often. After resident 38's incident, the staff checked on the residents when they went to bed and again at 1 a.m., 3 a.m., and 4 a.m. 4. Interview on 8/19/26 at 9:30 a.m. with CNA S revealed that she worked the night shift on 10/18/25 and had assisted resident 38 with personal cares. The staff were told after resident 38's incident that they had to check all residents every two hours. 5. Interview on 8/19/26 at 10:33 a.m. with RN T revealed that she worked the night shift on 10/18/25. RN T contacted DON B via text message regarding resident 38's incident, and then DON B called system DON O to come in to help the staff. RN T called resident 38's family, the funeral home, and completed the paperwork regarding resident 38's incident. Since resident 38's incident, RN T stated she would check on every resident during rounds regardless of the resident's ability to care for themselves. 6. Interview on 8/19/26 at 1:25 p.m. with DON B revealed that an incident such as resident 38's had never happened at the facility. She stated that the facility had 2 hours to notify the SD DOH of an unexpected death and acknowledged they failed to do so. 7. Interview on 8/19/26 at 2:51 p.m. with administrator A and DON B revealed that on 10/18/25, system DON O started an investigation regarding 38's incident and completed the investigation on Monday (10/20/25). Administrator A said the facility had 2 hours to notify the SD DOH of an unexpected death and acknowledged they failed to do so. 8. Interview on 8/20/26 at 8:15 a.m. with CNA J revealed that she was not sure of the reporting times for unexpected deaths, abuse, or neglect scenarios. She believed she had to notify DON B	F0609	By 9/18/2026, Assistant Administrator or designee will review and provide education to System DON O on: • the Abuse, Neglect, Mistreatment & Misappropriation of Resident Property LTC Division Policy, • the need to report to the SD Department of Health a serious bodily injury from an unknown source within two hours, • the need to contact the coroner prior to moving the body of deceased resident, • the Expired Patient, Care of, Coroner Case, Autopsy, Death Pronouncement policy. By 9/18/2026, Assistant Administrator or designee will review and provide education to Administrator A on: • the Abuse, Neglect, Mistreatment & Misappropriation of Resident Property LTC Division Policy, • the need to report to the SD Department of Health a serious bodily injury from an unknown source within two hours, • the need to contact the coroner prior to moving the body of deceased resident, • the Expired Patient, Care of, Coroner Case, Autopsy, Death Pronouncement policy. By 9/18/2026, Administrator or designee will review and provide education to Medical Doctor P on the Expired Patient, Care of, Coroner Case, Autopsy, Death Pronouncement policy and the criteria nurses will provide to the medical provider at the time of a resident's death, and that the provider may issue a telephone order to pronounce death after considering the nurse's assessment and observations. By 9/30/2026, all nurses and administrators will be educated on the DOH reporting system including how to access the system and reporting expectations. All employees on prn or on leave of absence status will complete this education prior to their return to work. By 9/18/2026, all direct care staff, including CNA U, CNA J, CNA Q, RN T, DON B, System DON O, and Administrator A will receive education on: • the Abuse, Neglect, Mistreatment & Misappropriation of Resident Property LTC Division Policy, • the need to report to the SD Department of Health a serious bodily injury from an unknown source within two hours, • the need to contact the coroner prior to moving the body of deceased resident, • the need to document what the nurse shares with the provider and what the provider shares to the nurse at the time of a resident's death, and • the Expired Patient, Care of, Coroner Case, Autopsy, Death Pronouncement policy. Education and attestation of completion and understanding is to be completed by 9/30/2026. All employees on prn or on leave of absence status will complete this education prior to	

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F0609 SS = D	Continued from page 13 within 24-48 hours if she suspected or had seen abuse, neglect, or a resident had an injury. 9. Interview on 8/20/26 at 8: 25 a.m. with CNA Q revealed that the staff had 48 hours to report any unexpected deaths, abuse, or neglect to DON B if she suspected or had seen abuse, neglect, or a resident had an injury. 10. Interview on 8/20/26 at 9:14 a.m. with RN F revealed the facility had to notify DON B immediately of any suspected abuse or neglect, and the facility had two hours to notify the SD DOH of the incident and investigation regarding resident 38.	F0609	their return to work. By 9/30/2026, all medical providers, including Medical Doctor P, will receive education on the Expired Patient, Care of, Coroner Case, Autopsy, Death Pronouncement policy and the criteria nurses will provide to the medical provide at the time of a resident's death, and that the provider may issue a telephone order to pronounce death after considering the nurse's assessment and observations. Beginning 9/14/2026, Director of Nursing or designee will perform Safety Rounding Documentation audits for all days for two weeks to ensure that staff are completing safety rounds per the FRHS Falls and Accidents policy. Assistant Administrator will report the result of the audits to the QAPI committee weekly. The QAPI committee will direct further audits. Beginning 9/14/2026, Director of Nursing or designee will complete Incident Timely Reporting Audits for all incidents requiring SD DOH incident reports including reports of serious bodily injury from an unknown source. Assistant Administrator will report the result of the audits to the QAPI committee weekly. The QAPI committee will direct further audits.	
F0880 SS = D	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 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	F0880	The facility will ensure that standard infection prevention practices will be followed for resident 15 and all other residents to ensure cleanable surfaces are utilized on adaptive equipment. On 8/31/2026, PT N applied a cleanable armrest adaptive device to Resident 15's wheelchair. On 9/10/2026, Director of Nursing checked Resident 15's and all other residents' wheelchairs for intact cleanable surfaces. On 9/7/2026, Administrator and Assistant Administrator reviewed the Wheelchair Inspection & Maintenance policy including: • "Nursing Home wheelchairs should be part of a regular cleaning schedule set forth by department management and performed by the Nursing Department (CNAs)," and • "All departments are responsible for identifying proper wheelchair function, integrity safety, and reliability. This includes but is not limited to...Intact seat, back, and armrests (no cuts or tears)." On 9/7/2026, Administrator and Director of Quality and Infection Control reviewed the Infection Control Program Policy including: • Goals to: o prevent transmission of diseases within FRHS, o prevent Healthcare Associated Infections (HAI's), o maintain a sanitary environment for patients, residents and staff, o provide appropriate infection control education to staff • all personnel will determine Infection Control risks throughout the facility and ensure compliance with Federal, State and CDC infection control regulations	9/30/26

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F0880 SS = D	Continued from page 14 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, and policy review, the provider failed to ensure standard infection prevention practices were followed regarding one of one sampled resident (15) with a towel used for padding on the resident's wheelchair armrest that was not a cleanable surface. Findings include: 1. Observation on 8/19/26 at 11:19 a.m. in the dining room revealed resident 15 sitting in his wheelchair at a table with two other residents. Green Coban (a	F0880	On 9/11/2026, Director of Quality and Infection Control updated Adaptive Equipment cleaning list to include documentation that all adaptive equipment is intact and cleanable. By 9/18/2026, Assistant Administrator or designee will review and provide education to MDS/IP H that: • All staff are responsible to prevent healthcare-associated infections, to maintain a sanitary environment for patients, residents, and staff, and to provide appropriate infection control education to staff and determine infection control risks throughout the facility and ensure compliance with regulations, this includes the requirement to have cleanable surfaces on resident's wheelchair (including armrests), • all staff are responsible for identifying proper wheelchair function, integrity, safety and reliability, • all adaptive equipment must be a cleanable surface, and • Coban is not a cleanable surface. By 9/18/2026, Assistant Administrator or designee will review and provide education to PT N that: • All staff are responsible to prevent healthcare-associated infections, to maintain a sanitary environment for patients, residents, and staff, and to provide appropriate infection control education to staff and determine infection control risks throughout the facility and ensure compliance with regulations, this includes the requirement to have cleanable surfaces on resident's wheelchair (including armrests), • all staff are responsible for identifying proper, wheelchair function, integrity, safety and reliability, • all adaptive equipment must be a cleanable surface , and • Coban is not a cleanable surface. No education will be provided to CNA G as CNA G is no longer employed at this facility. By 9/18/2026, Assistant Administrator or designee will review and provide education to CNA K that: • All staff are responsible to prevent healthcare-associated infections, to maintain a sanitary environment for patients, residents, and staff, and to provide appropriate infection control education to staff and determine infection control risks throughout the facility and ensure compliance with regulations, this includes the requirement to have cleanable surfaces on resident's wheelchair (including armrests), • all staff are responsible for identifying proper wheelchair function, integrity, safety and reliability, • all adaptive equipment must be a cleanable surface, and • Coban is not a cleanable surface. No education will be provided to CNA G as CNA G is no longer employed at this facility. By 9/18/2026, Assistant Administrator or designee will review	

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(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
F0880 SS = D	Continued from page 15 stretchy, self-adherent medical wrap that sticks only to itself and not to skin, hair, or clothing) was wrapped around the edges of a white towel that covered the right armrest of resident 15's wheelchair to provide a cushioned padding for the resident's right elbow and forearm. As resident 15 ate, his right arm alternated between resting in his lap, resting on the covered wheelchair armrest, and dangling over the wheelchair armrest with his hand touching the right wheel of his wheelchair. 2. Interview on 8/19/26 at 1:20 p.m. with resident 15 revealed that the therapy staff constructed the Coban and towel wheelchair armrest cushion to provide supportive padding for his right forearm and elbow. He did not know if it was ever cleaned. 3. Review of resident 15's electronic medical record (EMR) revealed he admitted to the facility on 4/30/26. His diagnoses included nontraumatic intracerebral hemorrhage (a sudden bleed inside the brain tissue, commonly referred to as a stroke, caused by a medical condition rather than an injury or accident), and polyneuropathy (a medical condition where multiple peripheral nerves throughout the body malfunction at the same time, causing numbness, tingling, burning pain, and muscle weakness). He had an 8/3/26 Brief Interview for Mental Status score of 10, which indicated his cognition was moderately impaired. 4. Review of the Coban manufacturer's instructions for use (IFU) identified Coban as a single-use medical supply item made of porous material (a surface that physically traps bacteria inside tiny cracks, gaps, and pores) that absorbs liquids, sweat, and dirt, and loses its structural integrity when washed or sanitized. The manufacturer's IFU indicated that Coban was generally intended to be worn for 24 to 48 hours at a time, or until it became soiled or wet. 5. Interview on 8/19/26 at 1:30 p.m. with minimum data set (MDS) specialist/infection preventionist (IP) H revealed she did not know who put the Coban and towel padding on resident 15's wheelchair armrest, but she assumed it was the therapy staff. She did not know if the night-shift certified nursing assistants (CNAs) cleaned that padding when they cleaned the residents' wheelchairs. She thought the padding could be cleaned with Germicide (a brand of disposable wipes containing chemicals that destroy	F0880	and provide education to CNA K that: • All staff are responsible to prevent healthcare-associated infections, to maintain a sanitary environment for patients, residents, and staff, and to provide appropriate infection control education to staff and determine infection control risks throughout the facility and ensure compliance with regulations, this includes the requirement to have cleanable surfaces on resident's wheelchair (including armrests), • all staff are responsible for identifying proper wheelchair function, integrity, safety and reliability, • all adaptive equipment must be a cleanable surface, and • Coban is not a cleanable surface. By 9/18/2026, Assistant Administrator or designee will review and provide education to DON B that: • All staff are responsible to prevent healthcare-associated infections, to maintain a sanitary environment for patients, residents, and staff, and to provide appropriate infection control education to staff and determine infection control risks throughout the facility and ensure compliance with regulations, this includes the requirement to have cleanable surfaces on resident's wheelchair (including armrests), • all staff are responsible for identifying proper wheelchair function, integrity, safety and reliability, • all adaptive equipment must be a cleanable surface, • Coban is not a cleanable surface, and • any uncleanable surfaces must be removed from adaptive equipment. By 9/30/2026, all direct care staff, including CNA K, MDS/IP H, PT N, and DON B (CNA G is no longer employed at this facility) will receive education that: • All staff are responsible to prevent healthcare-associated infections, to maintain a sanitary environment for patients, residents, and staff, and to provide appropriate infection control education to staff and determine infection control risks throughout the facility and ensure compliance with regulations, this includes the requirement to have cleanable surfaces on resident's wheelchair (including armrests), • all staff are responsible for identifying proper wheelchair function, integrity, safety and reliability, • all adaptive equipment must be a cleanable surface, and • Coban is not a cleanable surface. Education and attestation of completion and understanding is to be completed by 9/30/2026. All employees on prn or on leave of absence status will complete this education prior to their return to work. Beginning 9/14/2026, Director of Nursing or designee will perform four Adaptive Equipment Cleaning and Intactness Observation audits weekly to ensure Resident 15's and all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435112	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	**510 E 8TH ST POST OFFICE BOX 370, FREEMAN, South Dakota, 57029**

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F0880 SS = D	Continued from page 16 germs). If visibly soiled Coban wrap was on the resident's arm, rather than on his wheelchair, she expected the staff to replace it rather than clean it. 6. Interview on 8/19/26 at 2:30 p.m. with director of facilities E revealed he thought that the maintenance staff would repair the residents' wheelchairs with new parts, rather than tape them up. He assumed the nurses or CNAs put the Coban and towel on resident 15's wheelchair armrest to provide extra padding. If the staff had brought resident 15's wheelchair to the maintenance team to repair, he would have removed the Coban wrap and towel because it was an uncleanable surface. 7. Interview on 8/19/26 at 2:10 p.m. with physical therapist (PT) N revealed she tried several adaptive wheelchair armrest devices to relieve pressure on resident 15's right forearm and elbow. Most covered arm rests use Velcro straps to keep the armrest in place, which could be unstable if resident 15 leaned hard on the armrest. She monitored the resident 15's wheelchair armrest padding regularly and replaced the Coban and towel three times after they became visibly soiled. She agreed that Coban was a porous product that should be replaced rather than cleaned. 8. Interview on 8/19/26 at 3:04 p.m. with CNA G revealed the night shift CNAs were to clean the residents' wheelchairs. She thought the nurse or physical therapist changed the towel and Coban armrest padding on resident 15's wheelchair if it was dirty. 9. Interview on 8/20/26 at 8:55 a.m. with CNA K revealed she thought the therapy staff provided the towel and Coban armrest padding and were responsible for cleaning the padding. 10. Interview on 8/20/26 at 9:25 a.m. with PT and director of rehab M revealed he was not aware of the Coban and towel padding on resident 15's wheelchair armrest. He expected any adaptive device to be cleaned regularly and Coban to be removed and replaced regularly, rather than cleaned. He said, "We should find something for him [to have on his wheelchair armrest] that is a washable or cleanable surface."	F0880	other resident's adaptive equipment including wheelchair seat cushions are utilized appropriately and adaptive equipment is intact and cleanable. Assistant Administrator will report the results of the audits to the QAPI Committee weekly. The QAPI committee will direct further audits. Beginning 9/14/2026, Director of Nursing or designee will perform weekly Adaptive Equipment Cleaning & Intactness Documentation audits to ensure that resident 15's and all other residents' adaptive equipment documentation, including wheelchair armrests, is completed including that equipment is cleanable, cleaned, and intact. Assistant Administrator will report the results of the audits to the QAPI Committee weekly. The QAPI committee will direct further audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435112	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2026

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F0880 SS = D	Continued from page 17 11. Interview on 8/20/26 at 9:49 a.m. with director of nursing (DON) B revealed she stated that a porous material like Coban only poses an infection control risk "if it is visibly soiled." She expected the CNAs to clean resident 15's Coban and towel padding on his wheelchair armrest each night using Super Sani-Cloth Germicidal Disposable Wipes (disinfectant wipes used to clean, deodorize, and rapidly kill bacteria, viruses, and fungi on hard, non-porous environmental surfaces and medical equipment). When the Coban and towel padding became visibly soiled, she expected the CNAs to take the wheelchair into the shower room to clean and disinfect it. 12. Review of the provider's February 2026 Wheelchair Inspection and Maintenance policy revealed that the CNAs were to regularly clean resident wheelchairs, the maintenance staff were to repair them, and all staff were responsible for identifying proper wheelchair function, integrity, safety, and reliability. 13. Review of the provider's 11/22/22 infection control program policy revealed the policy was to prevent transmission of diseases within FRHS, to prevent healthcare-associated infections, to maintain a sanitary environment for patients, residents and staff, and to provide appropriate infection control education to staff. All personnel would determine infection control risks throughout the facility and ensure compliance with federal, state, and CDC infection control regulations.	F0880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435112	A. BUILDING B. WING	08/18/2026

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E0000	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 on 8/18/26. Oakview Terrace was found in compliance.	E0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carla Thiel	CEO/Administrator	9/11/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435112	A. BUILDING 01 - MAIN BUILD... B. WING	08/18/2026

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 8/18/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Oakview Terrace was found in compliance.	K0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Courtney Thiel	CEO/Administrator	9/11/26

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 _____	08/20/2026

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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 8/18/26 through 8/20/26. Oakview Terrace was found in compliance.	S 000		

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

TITLE: CEO/Administrator

(X6) DATE: 9/11/26