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

ORIGINAL

PRINTED: 05/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435112		05/04/2016

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) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 34030 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/2/16 through 5/4/16. Oakview Terrace was found not in compliance with the following requirement(s): F278 and F514.	F 000	*Addendums noted with an asterisk per 6/14/16 per telephone with facility administrator. SW/SDDOH/EL	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	1) Daily Resident Incontinent Prevention (DRIP) Assessment will be completed with each Admission, Quarterly, and significant Change MDS assessment. *for all residents on a toileting program. SW/SDDOH/EL 2) Daily Resident Incontinence Prevention (DRIP) Assessment was completed for resident #5 with Quarterly MDS with ARD date of 5-17-16. *[redacted] 6) QA audits for completion of DRIP assessment will be completed weekly by DON or her designee for 1 month, then if substantial compliance is reached, quarterly for 9 months. Audit results will be reported at the monthly QI meetings. *5/24/16 SW/SDDOH/EL SW/SDDOH/EL *3) Daily resident incontinence prevention (DRIP) assessment was completed for resident #1 with Quarterly MDS with ARD date of 5/24/16. SW/SDDOH/EL *4) Daily resident incontinence prevention (DRIP) assessment will be completed for resident #4 with quarterly MDS with ARD date 8/2/16. SW/SDDOH/EL *5) MDS coordinators were individually educated regarding #1-4 above on 5/24/16 by DON. SW/SDDOH/EL	

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

Nicholas R. Brandner — CEO — 5-24-16

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.

RECEIVED MAY 27 2016 SD DOH L&C

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review, interview, and instructions review, the provider failed to complete quarterly assessments for three of three sampled residents (4, 5, and 7) on a toileting program. Findings include: 1. Review of the resident 4's medical record revealed: *A Daily Resident Incontinence Prevention (DRIP) assessment (determines resident's toileting patterns) was completed along with the admission and significant change Minimum Data Set assessments. -The three-day DRIP admission assessment was completed 3/18/15 through 3/20/15. -The three-day DRIP significant change assessment was completed 11/17/15 through 11/19/15. -No quarterly assessments were completed when due in June 2015, September 2015, and February 2016. Interview on 5/4/16 at 3:20 p.m. with certified nursing assistant (CNA) B regarding resident 4 revealed: *Resident 4 would usually get restless when she had to use the bathroom. *Staff would ask her follow-up questions and she would respond appropriately. *She would urinate in the bathroom when taken. *CNA B felt resident 4 was rarely incontinent during the day. Surveyor: 16385	F 278		

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F 278	Continued From page 2 2. Review of resident 7's quarterly Minimum Data Set (MDS) assessment dated 3/1/16 revealed she had a scheduled toileting program to manage her urinary continence. Interview on 5/4/16 at 3:00 p.m. with registered nurse (RN) A confirmed resident 7 had a scheduled toileting program assessment. RN A had completed the assessment from 1/6/15 through 1/8/15 for resident 7's MDS admission assessment dated 1/12/15. Review of resident 7's medical record revealed no scheduled toileting program assessments had been completed for her quarterly MDS assessments on 9/15/15 and 3/1/16 or annual MDS assessment on 12/8/15. Surveyor: 34030 3. Review of resident 5's quarterly MDS assessment dated 2/23/16 revealed she had a scheduled toileting program to manage her urinary continence. Review of resident 5's medical record revealed: *A three day DRIP assessment from 9/30/14 through 10/2/14. *No further assessments had been found. Interview on 5/3/16 at 3:40 p.m. with RN A regarding resident 5 confirmed no other assessments had been done to determine the appropriateness of the resident's toileting program. Interview on 5/4/16 at 3:40 p.m. with the director of nursing regarding the residents' toileting program revealed she agreed the required assessments had not been done and should have	F 278		

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F 278	Continued From page 3 been. Review of the provider's undated DRIP Assessment Instructions revealed assessments "will be completed at a minimum at admission, with significant change, and each quarterly MDS."	F 278		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on closed record review, interview, and policy review, the provider failed to provide a complete and accurate medical record for one of two sampled residents (13) with disposition of the body following death (13). Findings include: 1. Review of resident 13's medical record and interview of director of nursing on 5/4/16 at 3:35 p.m. revealed: *The resident died on 2/15/16.	F 514	1) Death: Post Mortem Care Policy was revised 5-17-16. The policy was revised to indicate that there will be documentation of the physician being notified of the death, preparation of the body and the mortician receiving the body. *All residents have potential to be affected. SW/SDDOH/EL *3) SW/SDDOH/EL [redacted] QA audits for documentation of physician notified of death, preparation of body and mortician receiving the body will be completed weekly by DON or her designee for one month, then if substantial compliance is reached, quarterly for 9 months. Audit results will be reported at the monthly QI meetings. *5/24/16 SW/SDDOH/EL *2) Charge nurses - QA audit form will need to be signed off daily each shift whether a resident has passed or not. Charged nurses were individually educated at the beginning of their worked shifts by DON with completion for all currently employed nurses on 5/24/16. SW/SDDOH/EL	

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F 514	Continued From page 4 *There was no documentation of: -Care and preparation of the body for release following death. -Physician's order to release body to mortuary. -Where the body was released to. -When the body was released. -To whom the body was released. *The DON stated there should have been documentation by the nursing staff identifying where the body was sent. Review of the provider's 6/15/15 Death: Postmortem Care policy revealed: *The body should have been prepared for discharge. *The mortician should have been called. *There should have been documentation of any personal items sent with the mortician. *There should have been documentation of which mortician removed the body and the time.	F 514		

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	435112		05/03/2016

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OAKVIEW TERRACE	510 E 8TH ST POST OFFICE BOX 370 FREEMAN, SD 57029

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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/3/16. Oakview Terrace was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nicholas R. Brandner
TITLE: CEO
(X6) DATE: 5-24-16

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MAY 27 2016
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	10621		05/04/2016

NAME OF PROVIDER OR SUPPLIER: OAKVIEW TERRACE

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S 000	Compliance/Noncompliance Statement Surveyor: 34030 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/2/16 through 5/4/16. Oakview Terrace was found not in compliance with the following requirement(s): S115 and S169.	S 000	*Addendums noted with an asterisk per 6/14/16 per telephone with facility administrator. SW/SDDOH/EL	
S 115	44:73:01:07 Reports Each facility shall fax, email, or mail to the department the pertinent data necessary to comply with the requirements of all applicable administrative rules and statutes. Any incident or event where there is reasonable cause to suspect abuse or neglect of any resident by any person shall be reported within 24 hours of becoming informed of the alleged incident or event. The facility shall report each incident or event orally or in writing to the state's attorney of the county in which the facility is located, to the Department of Social Services, or to a law enforcement officer. The facility shall report each incident or event to the department within 24 hours, and conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event. Each facility shall report to the department within 24 hours of the event any death resulting from other than natural causes originating on facility property such as accidents. The facility shall conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event.	S 115	1) Falls resulting in serious injury including fractures will be reported to the Department of Health within 24 hours. 2) Fall Prevention and Management Policy was [redacted] revised on 5-17-16 to reflect the requirement to report all falls with 24 hours that result in serious injury. *5/24/16 SW/SDDOH/EL [redacted] QA audits for reporting falls with serious injury to the Department of Social Services will be completed by the Social Worker or her designee for one month, then if substantial compliance is reached, quarterly for 9 months. Audit results will be reported at the monthly QI meetings. *by the DON or her designee. SW/SDDOH/EL *4) SW/SDDOH/EL *3) charge nurses were individually educated at the beginning of their worked shifts by DON with completion for all currently employed nurses on 5/24/16. SW/SDDOH/EL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nicholas R. Brandner

TITLE: CEO

(X6) DATE: 5-24-16

STATE FORM 6899 GW0X11 If continuation sheet 1 of 5

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S 115	Continued From page 1 Each facility shall report a missing resident to the department within 48 hours. The facility shall conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event. Each facility shall also report to the department as soon as possible any fire with damage or where injury or death occurs; any partial or complete evacuation of the facility resulting from natural disaster; or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours. Each facility shall notify the department of any anticipated closure or discontinuation of service at least 60 days in advance of the effective date. Each facility shall report to the department any unsafe water samples for pools or spas. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35625 Based on record review, interview, and policy review, the provider failed to report a fall with serious injury to the South Dakota Department of Health (SD DOH) for one of one sampled resident (4) with a fall that resulted in a fracture. Findings include: 1. Review of resident 4's medical record revealed: *On 8/30/15 her quarterly Morse Fall Score (assessment done to determine risk or likelihood of falling) was 70, indicating she was at a high	S 115		

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S 115	Continued From page 2 risk for falls. *She: -Had an unwitnessed fall in her room on 11/9/15 at 3:10 a.m. -Had complaints of pain to her left hip and left wrist. -Was transferred to the hospital emergency room at 3:45 a.m. and was found to have a fracture of the left hip and left wrist. -Was transferred to a Sioux Falls hospital for surgical repair of the injuries. Interview on 5/4/16 at 1:55 p.m. and 3:20 p.m. with the director of nursing regarding resident 4's fall revealed: *An initial and final report was not submitted to the SD DOH for this fall. *She stated, "We don't submit one [report] just because of a fracture." *Acknowledged the fall was serious in nature and should have been reported. *She did not offer any additional feedback regarding why a report was not submitted to the SD DOH following this fall. Review of the provider's 4/6/09 Fall Prevention and Management policy revealed no information regarding when a fall was to be reported to SD DOH.	S 115		
S 169	44:73:02:18(5-7) Occupant Protection The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks;	S 169	1) The main door leading out of the nursing home to the front lobby and the two exit doors leading to staff areas and offices alarms will be activated at all times (24/7 [redacted] SW/SDDOH/EC	

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S 169	Continued From page 3 (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 34030 Based on observation and interview, the provider failed to maintain the electrically activated audible alarm at three of three exit doors (one main and two corridor exit doors). Findings include: 1. Observation on 5/2/16 at 6:30 p.m. of the main exit door leading out of the nursing home revealed the alarm was not activated. Observation on 5/3/16 at 2:00 p.m. revealed the main and two corridor exit doors were equipped with an audible alarm. The alarms were not activated at the time of the observation. The main exit door was within sight distance of the nurses station when staff were present. The two corridor exit doors lead out of the nursing home to staff areas and offices. At the end of those corridors were unlocked doors leading out of the facility. Interview on 5/4/16 at 10:30 a.m. with the head of maintenance confirmed the main and corridor exit alarm switches had been in the off position during the day hours from 5:00 a.m. until 8:00 p.m. He was not aware they needed to be monitored or alarmed during that time.	S 169	2) Staff and families will be educated on the new alarm procedure using newsletters, handouts, signs and departmental communication systems. After education, the procedure will be fully implemented on June 10, 2016. *6/10/16 SW/SDDOH/EL 3) Environmental Services Director and/or designee will monitor all three door alarms weekly for 3 months. Thereafter the monitor will be added to the "weekly preventative maintenance" program. The results of the weekly audits will be reported to the Quality Management Committee quarterly for one year. *by the environmental services director. SW/SDDOH/EL	

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S 169	Continued From page 4 Interview on 5/4/16 at 4:00 p.m. with the director of nursing regarding the exit doors revealed: *The exit doors would alarm for those residents with a Wandergard (a device worn by residents who are known to try to leave a facility.) Not all residents wore them. *She understood other residents could be at risk for exiting out of the facility unnoticed. No policy regarding this was provided at time of exit.	S 169		
S 000	Compliance/Noncompliance Statement Surveyor: 34030 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 5/2/16 through 5/4/16. Oakview Terrace was found in compliance.	S 000		