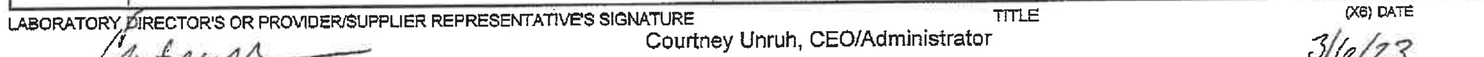
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435112	A. BUILDING ______ B. WING ______	02/15/2023

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 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 2/13/23 through 2/15/23. Oakview Terrace was found not in compliance with the following requirement: F686.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Ongoing and timely skin assessments were conducted and documented by licensed nurses prior to the development of pressure ulcers for three of three sampled residents (9, 28, and 33) who had been identified as at risk for pressure ulcers. *Complete and accurate ongoing documentation of identified pressure ulcers for three of three sampled residents (9, 28, and 33) who developed pressure ulcers. Documentation to reflect:	F 686	• The DON and/or the designee will ensure that ongoing and timely skin assessments will be conducted and documented by a licensed nurse prior to the development of pressure ulcers for all residents identified at risk for pressure ulcers. • On 3/3/2023, Skin Policy & Procedure was updated to include the following language: o "Risk Levels will be defined per Braden scores. Per risk level and frequency outlined below*, licensed nurses will conduct and document ongoing and timely skin assessments (including skin color, moisture, temperature, integrity, and turgor): ▪ At Risk – Braden score of 15-18 – assessed on admission & quarterly & with significant changes ▪ Moderate Risk – Braden score of 13-14 – assessed on admission & weekly & with significant changes ▪ High Risk – Braden score of 12 or less – assessed on admission & weekly & with significant changes ▪ * May need to assess more often if indicated, such as when the resident is utilizing medical devices that may cause pressure (TED hose, prosthesis, oxygen tubing, slings, etc.) or has other clinical factors."	3/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Courtney Unruh, CEO/Administrator (X6) DATE: 3/6/23



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 MAR 06 2022

(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 686	Continued From page 1 -Location and staging. -Size, depth, and presence, location and extent of any undermining g or tunneling. -Exudate, if present. -Pain, if present. -Wound bed, color and type of tissue/character, including evidence of healing. -Description of wound edges and surrounding tissues as appropriate. Findings include: 1. Observation and interview on 2/14/23 at 11:24 a.m. with resident 9 in his room revealed he: *Was sitting in a wheelchair on a ROHO pressure relieving cushion. There was a pressure relieving cushion in his recliner. *Had a prosthetic on his right leg and said the amputation above his knee happened in the past year due to his diabetes. *Received a whirlpool bath with staff assistance once a week. *Walked with staff three times a day in the hallway. *Had reported pain to his "back side" several months ago, and then the nurse looked and found a sore on his "bottom." *Now, they were looking at it every day, they had placed a patch over it, and the pain was finally getting better. Review of resident 9's medical record revealed: *He was admitted on 12/27/21. *His diagnoses included Type 2 diabetes with neuropathy, peripheral vascular disease, muscle weakness, right above the knee amputation, left toe amputation, malignant neoplasm of the bone and prostrate, and chronic kidney disease stage 3. *The Minimum Data Set (MDS) assessments	F 686	○ "Only licensed nurses are able to complete skin assessments. Certified nursing assistants are not able to complete skin assessments as it is not in their scope of practice." ○ "A nurse identifying or assessing a new skin issue will promptly document a thorough assessment in the EMR, including the following as applicable per wound type: ▪ Location & staging. ▪ Size, depth, and presence, location & extent of any undermining or tunneling. ▪ Exudate, if present. ▪ Pain, if present. ▪ Wound bed, color and type of tissue/character, including evidence of healing. ▪ Description of wound edges and surrounding tissues as appropriate." • On 3/2/2023, Director of Quality and MDS RN implemented a new EMR skin assessment titled "PCC Skin & Wound – Total Body Skin Assessment – OVT" to be used for all skin assessments required weekly and quarterly per policy that requires areas of assessment of: ○ Location & staging. ○ Size, depth, and presence, location & extent of any undermining or tunneling. ○ Exudate, if present. ○ Pain, if present. ○ Wound bed, color and type of tissue/character, including evidence of healing. ○ Description of wound edges and surrounding tissues as appropriate."	

(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 686	Continued From page 2 dated 1/3/22 at admission and the significant change assessments dated 2/10/22, 6/8/22, 9/3/22, and 12/27/22 all coded him at risk for developing a pressure ulcer and he had a pressure reducing device for his bed and his chair. None of them coded the presence of a pressure ulcer until the 12/27/22 MDS that coded a Stage 2 pressure ulcer (top two layers of skin broken open, usually tender and painful, may also be an intact or broken open filled blister). *His Brief Interview for Mental Status (BIMS) score was 15 on all the above MDS assessments, and that indicated he was cognitively intact. *All eight Braden Scale assessment scores (used to determine the risk of developing a pressure ulcer) completed in 2022 indicated he was at risk for developing a pressure ulcer. *Skin/Wound Note documentation included: -On 12/28/21 00:12 a.m., "No skin issues at this time noted other than recent amputation of right great toe with wound vac [vacuum] attached. dressing CDI [clean, dry, intact] with scheduled changes." -On 4/19/22 1:07 p.m., "Resident has what appears to be a red welted area on his right buttock. Will continue to monitor and pass on to other shifts." -On 5/1/22 2:38 p.m., "Resident has areas on inner coccyx that are deep red and look like they are about ready to open. Zinc spray applied and ROHO cushion placed in chair. Encourage resident to sleep with a pillow under one side and turn frequently when in bed to prevent further breakdown." -On 5/2/22 1:07 p.m., "This RN [registered nurse] looked at resident bottom. Noted open area to left buttock with redness around the area. Area hard touch. No blanching. Resident does have scar	F 686	• On 3/3/2023, MDS RN updated Braden assessments for residents 9, 28, and 33 and all other residents. • On 3/3/2023, MDS RN completed a skin assessment for residents 9, 28, and 33 and all other residents identified at moderate or high risk per updated policy. • Beginning 3/6/2023, DON and/or designee will audit all residents for required documentation of skin assessments weekly for eight weeks to ensure timely skin assessments are documented. DON or designee will report the results of the audits to the QAPI committee monthly. The QAPI committee will direct further audits. • The DON and/or designee will ensure complete and accurate ongoing documentation for pressure ulcers for residents 9, 28, and 33 and all other residents who have identified pressure ulcers. This documentation will include: o Location & staging. o Size, depth, and presence, location & extent of any undermining or tunneling. o Exudate, if present. o Pain, if present. o Wound bed, color and type of tissue/character, including evidence of healing. o Description of wound edges and surrounding tissues as appropriate. • On 3/2/2023, Skin Policy & Procedure was updated to include the following language: o "EMR documentation for wounds includes assessment and accompanying photo. Photos are used only to support the documentation of nurse or other licensed care provider."	

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 ______	02/15/2023

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 686	Continued From page 3 tissue noted above open area. Area noted to have no s/sx [signs/symptoms] of infection and no odor. Noted edges to be wet. Resident did have pressure reducing air mattress and resident wanted to [the] air mattress taken off bed. Again this RN asked resident if he would think about air mattress told this RN to 'Keep thinking. I am not having that on my bed.' Resident does have pressure relieving cushion in recliner and wheelchair. Resident was cleaned up and area dried. Cream applied to area. This RN instructed staff and resident that he needs to relieve pressure off of bottom every two hours. Staff verbalized understanding. Resident also verbalized understanding. Will continue to monitor." -On 8/17/22 5:44 p.m., "Resident has an area on buttocks that is very thin and has previously been open. This is currently being covered with a hydrocellular [silicone] foam dressing to protect the thin skin from shearing when resident slides forward in his w/c [wheelchair], recliner, or bed." -On 9/3/22 9:36 a.m., "Resident has open areas on sacrum that are bleeding at this time. Area cleansed thoroughly and dressing applied. Will continue to monitor and update other staff." -On 9/16/22 11:07 a.m., "Dressing removed from bottom area does have a foul smell however, suspect it could be from old drainage. dressing was not reapplied. would like to be able to monitor without dressing for a couple of days. nursing to utilize barrier cream at this time." -On 11/6/22 2:43 p.m., "Resident's coccygeal area shows the fragile epithelialization to be opening up in two spots. Area was gently cleansed and Medihoney and a hydrocolloid dressing [two layers of beginning biodegradable, breathable, and adhesive material] was placed to cover. Will monitor closely."	F 686	o "Only licensed nurses are able to complete skin assessments. Certified nursing assistants are not able to complete skin assessments as it is not in their scope of practice." o "All skin injuries (including but not limited to: pressure ulcers, moisture-associated skin damage, skin tears, rashes, lacerations, and abrasions) will receive daily monitoring by the charge nurse. Documentation at a minimum of a Weekly Skin Assessment to include the following as applicable per wound type: ▪ location and stage ▪ size, depth, and presence, location, and extent of any undermining or tunneling, ▪ exudate, in present, ▪ pain, of present, ▪ wound bed, color, and type of tissue/character, including evident of healing, ▪ description of wound edges and surrounding tissues, and ▪ efficacy of treatment." • On 3/1/2023, MDS Coordinator, Director of Quality, and Assistant Administrator updated EMR wound assessment documentation to require completion of all fields prior to assessment sign-off including: o Location & staging. o Size, depth, and presence, location & extent of any undermining or tunneling. o Exudate, if present. o Pain, if present. o Wound bed, color and type of tissue/character, including evidence of healing. o Description of wound edges and surrounding tissues as appropriate.	

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 ______	02/15/2023

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 686	Continued From page 4 *His current medical orders included the following: -Juven nutritional supplement twice daily for wound healing. -Medihoney applied topically to the wound bed on his coccyx and then covered with a wound dressing every three days or sooner if the dressing became contaminated. -Nursing to check his coccyx wound/dressing daily and change it [the dressing] as needed until it [the wound] healed. Review of resident 9's care plan regarding skin integrity initiated on 1/14/22 and revised through 2/13/23 revealed: *Impairment of skin integrity at his coccyx related to peripheral vascular disease, type 2 diabetes, and stage 3 chronic kidney disease. *Interventions to prevent pressure ulcers and then to promote wound healing included: -A pressure reducing air mattress on his bed, that he refused, so after he was educated about the risks, the air mattress was replaced with a different pressure reducing mattress. -A pressure relieving cushion in his recliner and wheelchair. -Wound dressings to be completed as ordered by his physician. Observation and interview on 2/15/23 from 12:25 p.m. to 1:14 p.m. with RN B while performing wound care for resident 9 revealed: *Resident 9's stage 2 coccyx pressure ulcer was discovered when he complained about pain in his coccyx area. *They had placed a pressure reduction mattress on his bed, but he did not like it. He was educated on the risk versus benefits but still wanted it removed, so they honored his choice.	F 686	• On 3/1/2023, Wound Champion RN completed documentation with updated EMR assessment for residents 9, 28, 33, and all other residents with wounds. • Beginning 3/6/2023, DON and/or designee will audit all residents for required documentation of wound assessments weekly for eight weeks to ensure complete & accurate wounds assessments. DON or designee will report the results of the audits to the QAPI committee monthly. The QAPI committee will direct further audits. • All direct care staff, including Director of Nursing, RN B, and CNA's C & D, received education titled "Avera LTC AADNS Helping Reduce Pressure Ulcers" as part of 2022 mandatory education. "Avera LTC AADNS Helping Reduce Pressure Ulcers" course assigned on 3/3/2023 for all direct care staff to review and complete again by 3/11/2023. All employees on PRN or leave of absence status will complete this education prior to their return to work. • On 3/5/2023, all direct care staff, including Director of Nursing, RN B, and CNA's C & D, were assigned education on the updated Skin Policy & Procedure which includes their roles and responsibilities within their scope of practice in conducting and documenting skin assessments. Education and attestation of completion and understanding is to be completed by 3/11/2023. All employees on PRN or leave of absence status will complete this education prior to their return to work.	

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 ______	02/15/2023

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 686	Continued From page 5	F 686		

*He had a gel cushion in his recliner and wheelchair until the pressure ulcer was discovered and then a ROHO cushion was placed in his recliner and wheelchair.
*His stage 2 pressure ulcer was healing.

2. Observation and interview on 12/14/23 at 10:47 a.m. with resident 33 revealed he:
*Was sitting in a wheelchair on a pressure relieving cushion.
*Was able to move himself in his wheelchair using his arms and feet to his wife's room in a different location of the facility to visit her, and he did that several times a day.
*Required assistance from staff for dressing and bathing.
*Had compression stockings and shoes on his feet.
*Denied any skin breakdown or skin concerns.

Review of resident 33's medical record revealed:
*He was admitted on 9/20/22.
*His diagnoses included: History of venous thrombosis and embolism, pulmonary embolism without acute cor pulmonale, cerebral infarction, and aphasia.
*The MDS assessment dated 9/27/22 at admission and the 12/9/22 significant change MDS coded him as at risk for developing a pressure ulcer, and there was a pressure reducing device for his bed and chair.
*His BIMS score on the 9/27/22 MDS was 15 and then 13 on the 12/9/22 MDS, both indicating he was cognitively intact.
*All five Braden Scale assessment scores completed in 2022 indicated he was at risk for developing a pressure ulcer.
*Skin/Wound Note documentation included:
-On 11/7/22 6:12 a.m., "Resident had scab/corn

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 ______	02/15/2023

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 686	Continued From page 6 on left great toe in two spots." -On 2/10/23 9:00 a.m., "This RN was informed of sore on resident left great toe. This RN assessed left great toe noted area to tip of left great toe with slight amount of drainage blood tint colored. Resident denies any pain to left foot or toe. After talking with staff noted that resident does wear TED [thromboembolism-deterrent] hose and the TED hose are tight to his toes. Right now resident just has gripper socks on and the socks are pulled away from his toes. Dressing was applied to left great toe. Order sent over to PCP [primary care physician] for Aquacel dressing for the great left toe. Resident son [name] notified of area on great left toe. Dietician notified of area on left great toe. Will continue to monitor. " -On 2/11/23 4:12 p.m., "CNA [certified nursing assistant] assessed resident's toe. He denied pain but stated he did feel some pain with cleansing of the wound. He states that he feels pressure and touching on his foot in general and his pedal pulses are palpable. His foot is normal temp [temperature] for his body. The wound bed is dark red granulation tissue with pale, hard tissue immediately surrounding, almost like an old blister. the periwound [sic] is dark red. Area cleansed and a hydrocolloid dressing applied." -On 2/13/23 2:00 p.m., "This wound was rechecked as it did say right instead of left great toe. [physician] did see wound on Friday 2/10 and today 2/13. [resident 33] was started on antibiotics and he also will not wear TED hose as there is pressure from the TED hose. Also will talk with family about getting new shoes that are softer. Dressing continues to be foam to help keep moisture away from the wound." *His current medical orders included: -Juven nutritional supplement twice daily for wound healing.	F 686		

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 ______	02/15/2023

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 686	Continued From page 7 -A podiatry referral. -Bactrim antibiotic two times daily for left great toe infection for five days. -Routine wound care for left great toe. -An X-ray of left great toe. *The X-ray results were negative for any bone infection. Review of resident 33's care plan regarding skin integrity initiated on 10/3/22 and revised through 2/11/23 revealed: *He had impairment to skin integrity related to a left great toe pressure ulcer. *Interventions to prevent pressure ulcers and then to promote wound healing included: -A pressure reducing mattress on his bed. -A pressure relieving cushion in his recliner and wheelchair. -Physician orders for antibiotics, wound dressings, a podiatry referral, and an X-ray of his left great toe. Observation and interview on 2/15/23 from 12:25 p.m. to 1:14 p.m. with RN B while performing wound care for resident 33 revealed: *The stage 2 left great toe pressure ulcer was discovered when a CNA was putting on his TED compression stockings, and she alerted the nurse. *He wore TED compression stockings for his 3 plus pitting edema [fluid retention], and they attributed his ulcer to the TED compression stocking rubbing on his toe. *The CNAs had been educated to pull the TED compression stocking away from the toe when they put them on. *They had ordered toeless TED compression stockings for him. *He had an X-ray of the toe "yesterday" and there	F 686		

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 ______	02/15/2023

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 686	Continued From page 8	F 686		

was no bone infection.
*He moved himself in his wheelchair with his arms and feet.
*He denied pain and said he did not feel the pressure ulcer on his toe, and "it does not hurt me".
*She further explained the process for identifying, reporting, and preventing the development of pressure ulcers included:
-The charge nurse completed a comprehensive skin assessment for residents at admission.
-Braden Scale assessments were completed by nursing at admission and quarterly with the MDS assessments and with significant changes.
-Interventions such as cushions in chairs and wheelchairs, pressure reducing mattresses, and repositioning were put in place for residents at risk for skin breakdown.
-Skin concerns or changes were identified and reported to nursing staff by CNA observations while assisting with personal care and bathing, or by residents reporting their concerns.
-Once the nurse received a report of skin concerns or changes, the nurse would complete a skin assessment, decide on the plan of care and treatment, notify the physician for treatment orders, implement daily skin/wound checks, and complete weekly wound assessments with measurements.

Interview on 2/15/23 at 3:49 p.m. with director of nursing (DON) A regarding nurses completing skin assessments revealed:
*Braden Scale assessments were completed for residents by the nurse on admission, quarterly with the MDS and with any significant changes.
*If the Braden score indicated a resident was at risk for pressure ulcers, interventions were put into place, such as pressure relieving devices,

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 ______	02/15/2023

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 686	Continued From page 9 and repositioning programs. *A resident received a thorough skin assessment completed by the night charge nurse at admission. *CNAs observed resident's skin during personal cares and bathing and were to report to the charge nurse any skin concerns such as redness or bruising. *Outside of the CNA certification course that addressed dry skin, applying lotion etc... CNAs had no additional training for their delegated resident skin observations. *They held a daily huddle where staff were asked about any resident skin issues or observed skin changes. *When the charge nurse was notified of resident skin issues, she completed a skin assessment, notified the provider, and implemented a daily nurse skin/wound check. Interview on 2/15/23 at 6:12 p.m. with CNA D regarding skin observations revealed she: *Had worked at the facility for 50 years. *Had not received any additional training on observing residents' skin and/or wounds outside of her CNA certification course. *Completed skin observations when assisting residents with personal cares, activities of daily living and bathing. *Reported any observed resident skin concerns such as bruises, redness on the coccyx, under the breasts, armpits, skin folds or the feet to the charge nurse. *Had shared with the charge nurse any resident concerns voiced to her, such as redness or irritation in folds of skin or pain in pressure spots like bottoms or heels. *Attended the daily staff huddle and would bring up resident skin concerns at that time.	F 686		

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 ______	02/15/2023

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 686	Continued From page 10 *Had worked with residents who had skin concerns and had pressure ulcer prevention interventions in place such as, a gel or ROHO cushion, an alternating air mattress, a schedule to reposition every 2 hours, and/or a schedule to walk or go to the toilet depending on the resident's mobility. 3. Observation on 2/13/23 at 4:15 p.m. of resident 28 revealed she was sitting in a reclining chair with a blood-stained incontinence pad under her. Observation on 2/14/23 at 10:10 a.m. of resident 28 revealed she was still sitting in a reclining chair. Observation and interview on 2/15/23 at 12:15 p.m. with of resident 28 revealed she: *Was in her bed lying on her left side. *Called a small black cushion in the seat of the reclining chair her "special cushion." *Had a sore on her "bottom." *Did not know exactly when she got it, but said that she did not have it before moving in. Review of resident 28's medical record revealed: *She was admitted on 3/17/22. *The MDS assessment dated 3/24/22 at admission and the 1/10/23 significant change MDS coded her at risk for developing a pressure ulcer. She had a pressure reducing device for her bed and the chair. *The presence of one unstageable pressure ulcer and moisture associated skin damage were coded on the 1/10/23 MDS. *Her BIMS score on both the 3/24/22 and 1/10/23 MDS assessments were coded as 15 indicating she was cognitively intact.	F 686		

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 ____	02/15/2023

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 686	Continued From page 11	F 686		

Continued From page 11

*The skin/wound section revealed:
-No weekly skin assessments were documented after the initial screening on admission.
-Photo documentation of four open areas had developed (coccyx, sacrum, left hip, and left ear).
*The care plan was revised after the pressure ulcers had been identified with preventative measures implemented (gel and ROHO cushion).
*She had become compliant with her treatments.

Interview on 2/15/23 at 10:25 a.m. with RN B regarding resident 28 revealed:
*She did not have pressure ulcers prior to her admission to the facility.
*She had been noncompliant when first admitted to the facility, but she had been compliant with her treatment in the past few months.
*She was supplied pressure relieving equipment (gel and ROHO cushion) but continued to get pressure ulcers. RN B was not sure why she kept getting ulcers.
*CNAs look at residents' skin during bathing days and would let the nurse know of any concerns that were found.

Interview on 2/15/23 at 12:21 p.m. with director of nursing A about resident 28's pressure ulcer revealed:
*Resident 28 had obtained the pressure ulcers after her admission to the facility.
*No skin assessments had been completed in the 11 months after resident 28 had been admitted.
*CNAs were to check residents' skin during bathing and to notify the nurse of any identified issues.

Interview on 2/15/23 at 6:15 p.m. with CNA C revealed only the CNAs would check the residents for skin issues during bathing and

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 ______	02/15/2023

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 686	Continued From page 12 would inform the nurse if there were any identified skin issues. Review of the provider's 2/22 Skin Policy and Procedure revealed: *Full head-to-toe skin assessment was to be completed on admission and with significant changes to assess skin changes or breakdown. *The Braden Pressure Ulcer Risk Assessment tool was completed upon admission and with all MDS assessments. *Based on skin assessments, interventions were to be put into place. *Nurse Assistants were responsible to observe residents during daily care and especially during bathing and report concerns promptly to the charge nurse. *A nurse identifying a skin issue was to promptly document a thorough assessment in the medical record, determine treatment, and communicate the issue to staff. *The charge nurse was responsible to communicate skin concerns to physician and request treatment orders. *All skin injuries would receive daily monitoring by the charge nurses. *Documentation, at a minimum, of a weekly skin assessment would include skin injury location, type of injury, size, and integrity.	F 686		

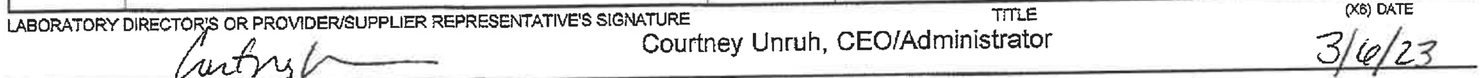
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435112	A. BUILDING ______ B. WING ______	02/15/2023

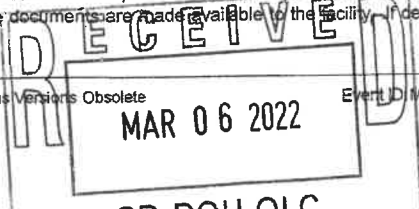
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	510 E 8TH ST FREEMAN, SD 57029

(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 2/13/23 through 2/15/23. Oakview Terrace was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Courtney Unruh, CEO/Administrator — (X6) DATE: 3/6/23



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

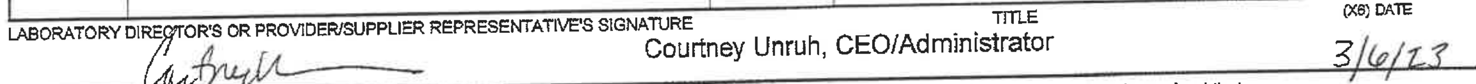
PRINTED: 02/24/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435112	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/14/2023

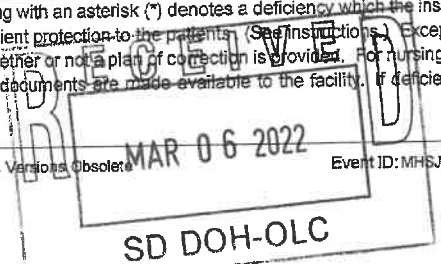
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	510 E 8TH ST FREEMAN, SD 57029

(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 2/14/23. 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: Courtney Unruh, CEO/Administrator | (X6) DATE: 3/6/23



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.



PRINTED: 02/24/2023
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 ______	02/15/2023

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 2/13/23 through 2/15/23. 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 2/13/23 through 2/15/23. Oakview Terrace was found in compliance.	S 000		

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

TITLE: Courtney Unruh, CEO/Administrator

(X6) DATE: 3/6/23