

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/26/2025
NAME OF PROVIDER OR SUPPLIER  Oakview Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 510 E 8th St Freeman, SD 57029	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, observation, record review, interview, and policy review, the provider failed to follow resident's care plans to:</p> <p>*Provide adequate supervision for one of one sampled resident (40) who was left unsupervised in the whirlpool tub by two certified nursing assistants (CNA) (K and Q).</p> <p>*Provide adequate assistance by one of one CNA (S) for one of one sampled resident (38) who fell and sustained an injury and pain that required evaluation at the emergency room.</p> <p>Findings Include:</p> <p>1. Review of the provider's 4/29/25 SD DOH FRI revealed:</p> <p>*On 4/28/25 at 4:15 p.m., CNAs O and P heard [resident 40] yell Hello from the [whirlpool] tub room, and went into [the whirlpool] tub room and noted [resident 40] sitting in the whirlpool [tub] without any staff member present.</p> <p>*CNA O immediately assisted resident 40 out of the [whirlpool] tub and back to her room.</p> <p>*The provider's investigation revealed that CNA K had initiated resident 40's bath and then had asked CNA Q to finish providing that bath. CNA Q then requested Charge Nurse [registered nurse (RN) R] tell CNA P to go into the [whirlpool] tub room to sit with [resident 40].</p> <p>*CNA Q kept moving assuming she [RN R] had passed on that message [to CNA P].</p> <p>*CNA O indicated she knew [CNA K] gave [resident 40] a bath and that [CNA K's] scheduled shift ended at 3:30 p.m.</p> <p>*When interviewed regarding that bath, resident 40 indicated, It was wonderful! I soaked and I enjoyed it!</p> <p>*When asked if she had to wait long after she called out, resident 40 stated, No, what [when] I was ready, I yelled Hello and a nice young lady came [in] right away.</p> <p>* .Poor communication and multiple assumptions amongst multiple staff impacted this situation.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*CNA Q was the last staff member in the [whirlpool] tub room with [resident 40] and should not have left [resident 40] alone in the [whirlpool] tub room .</p> <p>2. Interview on 6/24/25 3:40 p.m. with resident 40 and her power of attorney (POA) revealed:</p> <p>*Resident 40 recalled the above event when she was left alone in the whirlpool tub and stated, I loved it.</p> <p>*She indicated that she had been wearing a plastic safety strap and had not been worried or afraid when she was left alone. She had requested to soak in the whirlpool tub, and the staff had come into the room right away when she called out.</p> <p>*She knew CNA K had to leave that day while she was in the whirlpool tub, and that there had been a miscommunication between the staff about who was going to help her in getting out of the whirlpool tub.</p> <p>*She got herself washed and dressed each day, but was told after the incident on 4/28/25 that someone was supposed to have remained in the whirlpool tub room with her that day.</p> <p>*She had not been left alone in the whirlpool tub before the incident on 4/28/25 or since then.</p> <p>*She stated that she did not want anyone to get in trouble, she loved it there, and that the staff were my little angels.</p> <p>*Her POA stated that she had been informed of the incident, she had no concerns, and that resident 40 had shared with her it was the best bath.</p> <p>3. Review of resident 40's electronic medical record (EMR) revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her 2/20/25 Brief Interview of Mental Status (BIMS) assessment score was 9, which indicated she was moderately cognitively impaired.</p> <p>*Her 5/20/25 BIMS assessment score was 11, which indicated she was moderately cognitively impaired.</p> <p>*Her 2/26/25 revised care plan indicated she preferred a shower and required one staff member's assistance to get in and out of the shower, to wash her lower body, back, and hair.</p> <p>*Her 4/28/25 revised care plan indicated she preferred a shower and required one staff member's assistance to get in and out of the whirlpool tub, and to wash her lower body, back, and hair.</p> <p>*Her 5/28/25 revised care plan indicated she preferred a shower and required one staff member's assistance (SBA) [stand by assistance] to get in and out of the whirlpool tub. Once in the whirlpool [tub] [resident 40] is independent with bathing, staff [member] to stay in [the] room and assist as needed and requested by [resident 40].</p> <p>4. Observation on 6/25/25 at 9:00 a.m. of the nurses' station and whirlpool tub room revealed:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*The whirlpool tub room was located directly across from the nurses' station.</p> <p>*While standing at the furthest point away from that whirlpool tub room, at the nurses' station, the conversation between the staff and the resident in that whirlpool tub room was able to be heard over the noise of the whirlpool jets.</p> <p>5. Interview on 6/26/25 at 7:45 a.m. with director of nursing (DON) B revealed that CNA Q had resigned and was not available for an interview related to the 4/28/25 incident with resident 40.</p> <p>6. Interview on 6/26/25 at 10:13 a.m. with CNA K revealed:</p> <p>*On 4/28/25, she had been asked by CNA Q to provide resident 40 with a whirlpool bath. She had started that whirlpool bath; however, her shift ended at 3:30 p.m., and she needed to leave.</p> <p>*CNA K requested that CNA Q finish resident 40's whirlpool bath, and CNA K provided CNA Q with a verbal report in the whirlpool room of what tasks needed to be finished, and that resident 40 had requested to soak in the tub.</p> <p>*CNA K knew that resident 40 liked to take a long bath and indicated that she should not have started a bath that she could not finish before the end of her shift.</p> <p>*CNA K indicated that when she left the whirlpool tub room on 4/28/25, resident 40 was in the whirlpool tub, and CNA Q had agreed to complete resident 40's whirlpool bath; however, CNA K saw CNA Q leave the whirlpool tub room and heard CNA Q state that she would be right back.</p> <p>*CNA K had not worked with CNA Q before that incident and thought that CNA Q would have finished resident 40's whirlpool bath.</p> <p>*CNA K stated that staff members carried walkie-talkies to communicate with each other, but resident 40 had no way to alert staff of her need for assistance, while in the whirlpool, except to yell for help.</p> <p>*CNA K thought that resident 40 was safe to be in the whirlpool tub unattended for a short period because resident 40 was independent with bathing and dressing, did not need physical assistance with bathing while in the whirlpool tub, and had requested to rinse herself off with the hand-held shower.</p> <p>*CNA K could not recall if she had been told before that incident that residents were not to be left alone in the whirlpool tub.</p> <p>7. Interview on 6/26/25 at 11:40 a.m. with CNA O revealed:</p> <p>*On 4/28/25 she had heard CNA K tell CNA Q that she needed to leave at the end of her shift [3:30 p.m.] and that CNA Q had agreed to complete resident 40's whirlpool bath.</p> <p>*She did not know that CNA K and CNA Q had left resident 40 alone in the whirlpool tub.</p> <p>*She heard someone inside the whirlpool tub room say, Hello, I am done, from the nurses' station.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-She stated that resident 40's voice was calm.</p> <p>*When CNA O entered the whirlpool tub room, resident 40 was in the tub and no staff were present.</p> <p>*Resident 40 indicated that she was finished soaking and was ready to get out of the whirlpool tub, and then CNA Q arrived and assisted resident 40 out of the whirlpool tub.</p> <p>*CNA O was trained that for the resident's safety, she was never to leave a resident alone in the whirlpool tub or the shower, even if they were independent or requested to be alone.</p> <p>8. Interview on 6/26/25 at 12:24 p.m. with DON B and Minimum Data Set (MDS)/ registered nurse (RN) C regarding the incident with resident 40 on 4/28/25 revealed:</p> <p>*MDS/RN C had completed a skin assessment of resident 40 after that bath, and there were no concerns noted. Resident 40 stated she had enjoyed her bath.</p> <p>*DON B expected that the staff would remain in the whirlpool tub room for the entire time any resident was in the whirlpool tub for the resident's safety.</p> <p>*MDS/RN C stated no current resident was independent in the shower or the whirlpool tub.</p> <p>*Resident 40 should not have been left alone in the whirlpool tub.</p> <p>*CNAs were educated during their orientation that they needed to remain in the whirlpool tub room with a resident while they showered or took a bath, and that staff members could use the call light or walkie-talkies to call for help from other staff if needed.</p> <p>9. Review of the provider's 3/13/25 SD DOH FRI revealed:</p> <p>*Resident 38 was standing at the foot of her bed in front of her dresser when CNA S entered her room.</p> <p>*CNA S walked to [the] head of the bed while resident [38] remained at the foot of the bed, to pull down the sheets.</p> <p>*Resident 38 fell backward without warning and hit the back of her head.</p> <p>*Resident 38 was sent to the emergency department (ED) to be evaluated as she hit the back of her head and edema [swelling] was present .</p> <p>*Resident 38 reported headache, and pain to her head, neck, back, chest and pelvis since falling.</p> <p>*While at the hospital ED resident 38 experienced an episode of hypoxia [low level of oxygen in the body] after IV [intravenous] Fentanyl [a pain medication] with oxygen levels in the 80s and required 5 liters (L) of oxygen by nasal cannula (NC) (a flexible tubing that delivers oxygen through the nose) and returned to the facility on 1L of oxygen by NC.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Resident 38 required SBA [standby assistance of one staff member] with a walker in and out of her room.</p> <p>*CNA [S] should have assisted the resident to a safe position prior to pulling down the sheets in the bed and should not have left resident [38] standing by the dresser .</p> <p>10. Review of resident 38's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her 3/11/25 BIMS assessment score was 0, which indicated she was severely cognitively impaired.</p> <p>*Her 12/16/24 revised care plan indicated she required the assistance of one staff member with her walker. Resident 38 does need extra assistance if she is having extra pain and other times she will forget that she needs assistance and [will] get up without assistance.</p> <p>*Her 3/20/25 revised care plan indicated she required SBA of one staff member with her walker .</p> <p>*Her 3/11/25 fall risk assessment indicated she was at high risk for falls and knew her own limits.</p> <p>*A 3/13/25 progress note indicated, Resident [38] was standing by her dresser and fell backwards hitting her head on her the bathroom door. Injuries: edema on the back of her head. 10/10 [ten on a zero to ten pain scale] generalized pain . Resident transferred to ED for evaluation.</p> <p>11. Observation and interview on 6/24/25 4:08 p.m. with resident 38 revealed:</p> <p>*She was seated in her recliner with her call light next to her.</p> <p>*Her room was arranged as described in the FRI with her dresser at the foot of her bed. When the bathroom door was open, it aligned with the dresser. The room was uncluttered with both a wheelchair and a walker present.</p> <p>*She did not remember falling, did not know what she would use the call light for, and indicated that if she needed something, she would just get up and get it.</p> <p>*She was pleasant, answered basic questions, and denied having any pain.</p> <p>12. Interview by phone on 6/26/25 at 10:00 a.m. with CNA S revealed:</p> <p>*On 3/13/25, resident 38 was in her room, standing at the foot of her bed, by her dresser with her walker, when CNA S arrived to assist her with getting ready for bed. The dresser drawer was open, and she thought that resident 38 was getting her pajamas from the dresser.</p> <p>*CNA S stated that she had gone to pull back the blankets on the bed when she heard resident 38 fall and hit her head.</p> <p>*Resident 38 was in a lot of pain and called out loudly after she fell.</p> <p>(continued on next page)</p>		

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