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
	43A089	A. BUILDING B. WING	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White River Health Care Center	515 E 8TH STREET POST OFFICE BOX 310, WHITE RIVER, South Dakota, 57579

(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 7/7/26 through 7/9/26. White River Health Care Center was found not in compliance with the following requirements: F732, F755, F759, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/7/26 through 7/9/26. Areas surveyed included a resident who expressed suicidal ideation and was transferred to the hospital where he eloped from, and misappropriation of resident funds. White River Health Care Center was found in compliance.	F0000		
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F0755	F755 Pharmacy Srvcs/Procedures/Pharmacist/Records Resident 33 had no identified negative outcomes resulting in failed to ensure hand hygiene, glove use, and medication handling according to the pharmacy instructions by one identified LPN K during medication preparation and administration which included divalproex, a seizure medication with handling precautions. All residents have the potential to be affected by this finding. DON re-educated LPN K on proper handling of hazardous medication, medication administration, hand hygiene and glove use on 7/9/26. Facilities medication administration policy, hazardous drugs policy reviewed and revised 1:1 re-education done with LPN K on 7/30/26. Medication administration and blood glucose monitoring/cleaning/disinfecting done with LPN K on 7/30/26. Training modules assigned to all nurses and nurse aides on Basics of Medication Management and Avoiding common Medication Errors assigned on 7/21/26. The re-education is on going and staff will be educated before thier next shift.	8/2/2026

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
Brandi L Hodges	Administrator	8/2/2026

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F0755 SS = E	Continued from page 1 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure hand hygiene, glove use, and medication handling according to the pharmacy instructions by one of one observed licensed practical nurse (LPN) (K) during medication preparation and administration of one of one sampled resident's (33) medications, including divalproex, a seizure medication with handling precautions. Findings include: 1. Observation on 7/8/26 at 4:29 p.m. with LPN K while she prepared and administered resident 33's medications revealed LPN K removed a Flomax (a medication used to treat symptoms of an enlarged prostate)0.4 milligram (mg) capsule from the medication bubble package (a tool that organizes pills by the day and time) into her bare hand and placed that capsule on a tissue on the medication cart. She then then removed six capsules of divalproex sodium (a seizure medication) 125 mg from the bubble packaging, placed them into her bare hand, and then set them on the same tissue. With her bare hands she opened the Flomax and the divalproex capsules and placed the contents of those capsules into a medication cup with resident 33's other crushed medications and applesauce. She then administered those medications to resident 33. The six bubble pack medication cards of divalproex were labeled with directions to use gloves, hazardous medication on them. 2. Observation 7/8/26 at 4:20 p.m. of LPN K checking resident 20's blood sugar level and administering his insulin revealed LPN K performed hand hygiene, applied a pair of gloves, and checked resident 20's blood sugar level with a glucometer (a portable device used to measure the amount of sugar in the blood stream). With those same gloved hands, LPN K administered two insulin injections to	F0755	Competencies done with LPN K on Medication Administration and Glucose Monitoring/Cleaning/ Disinfecting on 7/30/26. Competencies with all other staffed nurses and nurse aides on 7/30/26 the competencies are on going nurses and medication aids will be educated before their next shift for those who haven't completed the re-education. The DON and/or designee will conduct weekly audits on nurses glucose checks, hand hygiene performed using medication, proper glove use, and proper handling of hazardous medication for 4 weeks then monthly for 3 months. The audit findings will be reviewed by QAPI committee with further recommendations as needed to ensure compliance.	

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F0755 SS = E	Continued from page 2 resident 20, removed her gloves, discarded them in the garbage can, picked up the glucometer and the insulin pens with her bare uncleaned hands, and exited resident 20's room. LPN K took the insulin pens and glucometer to the medication cart, and placed them on top of the medication cart. Without performing hand hygiene, she put a glove on her left hand, cleansed the glucometer with a disinfectant wipe, removed her glove, discarded it in the garbage can, and did not perform hand hygiene. LPN K put the insulin pens in the medication cart, documented resident 20's blood sugar in his medication administration record (MAR), and then performed hand hygiene. 3. Observation on 7/9/26 at 11:26 a.m. of LPN K at the medication cart, preparing and administering medications for resident 33 revealed that without performing hand hygiene, she put on a pair of gloves. With those gloved hands, she prepared resident 33's medications for administration, removed her gloves, discarded them in the garbage can, and did not perform hand hygiene. She placed thickener and flavoring into resident 33's water, put a piece of trash in the garbage can on the medication cart, and then performed hand hygiene. She took the prepared medication to resident 33 in the hallway and administered the medication. 4. Interview with on 7/9/26 at 12:45 p.m. with LPN D revealed the staff were to wear gloves when they handled resident's medications, including hazardous medications. 5. Review of the provider's 1/26/26 Hazardous Drugs list revealed that divalproex, also known as Depakote, was on the list of hazardous drugs. 6. Interview on 7/9/26 at 1:17 p.m. with director of nursing (DON) B revealed she expected the staff to wear gloves when preparing and administering hazardous medications to residents. 7. Interview on 7/9/26 at 1:17 p.m. with director of nursing (DON) B revealed she expected the staff to wear gloves, while performing blood sugar checks. She expected the staff to wear gloves when they handled any residents' medications with their hands, including hazardous medications.	F0755		

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F0755 SS = E	Continued from page 3 She expected staff to use alcohol-based hand sanitizer before they put on gloves and after they removed the gloves, and before and after administering medications to a resident. Review of the provider's 2001 Hazardous Drug policy revealed, "Hazardous pharmaceutical drugs are handled according to practice standards so as to minimize staff and resident exposure and environmental damage." "Hazardous drugs classified by NIOSH [National Institute for Occupational Safety and Health] are drugs that exhibit one or more of the following criteria: Carcinogenicity (linked to cancer); Teratogenicity (linked to birth defects); Developmental toxicity (linked to developmental delay); Reproductive toxicity; Organ toxicity in low doses (animals or humans); Genotoxicity (linked to DNA damage); and Any new drugs that mimic existing hazardous drugs in structure or toxicity." Review of the provider's 4/26/22 Handwashing/Hand Hygiene policy revealed "This facility considers hand hygiene the primary means to prevent the spread of infections." "Use an alcohol-based hand rub containing at least 62% [percent] alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...Before preparing or handling medications."	F0755		
F0732 SS = D	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F0732	F732 Posted Nurse Staffing Information Residents had no identified negative outcome resulting in failure to ensure the daily nurse staffing information, including the total number and the actual hours worked by registered nurses, licensed practical nurses, licensed vocational nurses, and certified nursing assistants per shift, was posted in a location visible and accessible to residents, staff, and visitors. Revision of current posted nurse staffing policy revised and displayed form on 7/30/26 by DON. DON and/or designee educate on new form on revised policy on 7/31/26 to all nursing staff. Nursing staff who have not completed the education will be educated before their next scheduled shift.	8/3/2026

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F0732 SS = D	Continued from page 4 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (Iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the daily nurse staffing information, including the total number and the actual hours worked by registered nurses, licensed practical nurses, licensed vocational nurses, and certified nursing assistants per shift, was posted in a location visible and accessible to residents, staff, and visitors. Findings include:	F0732	DON and/or designee will do audits weekly on the posted nurses staffing information form making sure it has facility name, current date, total number of scheduled and actual hours, making sure it is posted at the beginning of the shift and at the end of the shift, and accessible to all residents, visitors, and staff for 4 weeks then monthly for 3 months until substantial compliance is met. Audits will be taken to QA/QAPI committee by DON and/or designee with findings to be reviewed and recommendations done as needed to ensure compliance is met.	

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F0732 SS = D	Continued from page 5 1. Observation on 7/7/26 at 10:00 a.m. of a white dry-erase board on the wall across from the nurses' station revealed the staff had written the date, resident census, and number of nursing personnel working. The posted information was visible to the residents and visitors, but the actual hours worked by each staffing category (registered nurses, licensed practical nurses/licensed vocational nurses, certified nursing assistants) were not included. 2. Observation on 7/9/2026 at 9:27 a.m. revealed that the clipboard that had the daily staffing sheets hung on the wall next to the white dry-erase board across from the nurses' station. This is the same clipboard that had previously been hung behind the nurses' station. The clipboard with the sheet indicating the staff working was not readily accessible to the residents, staff, and visitors. 3. Observation and interview on 7/8/2026 at 9:56 a.m. with licensed practical nurse (LPN) D, revealed that the daily staffing information that indicated which nursing staff and Certified Nursing Assistants (CNA) staff were either working the day or night shift was written on the white dry-erase board across the hallway from the nurses' station. The daily staffing sheets were attached to a clipboard that hung on the wall behind the nurses' station. They were not visible to the residents and visitors. 4. Interview on 7/8/26 at 10:40 a.m. with resident 3 revealed he was not aware of the daily staffing sheets that were on the clipboard hanging behind the nurses' station. He stated, "I wouldn't know; I would not go back behind the nurses' station to look for the daily posting of staff." He indicated he was only aware of the staff information written on the white dry-erase board across from the nurses' station. 5. Review of the Nurse Staffing Posting Information policy dated 12/21/25 revealed "The Nurse Staffing Sheet will be posted on a daily basis and will contain the facility name, current date, facility's current resident census, the total number and the actual hours worked by registered nurses, licensed practical nurses/licensed vocational nurses, and certified nursing assistants, and unlicensed nursing staff directly responsible for resident care per shift. "The facility will post the	F0732		

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F0732 SS = D	Continued from page 6 Nurse Staffing Sheet at the beginning of each shift, and the information posted will be presented in a clear and readable format and in a prominent place readily accessible to residents, staff, and visitors."	F0732		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure a medication error rate of less than 5 percent related to Flomax (a medication used to treat an enlarged prostate) was administered on time, and was administered according to the physician's order for one of one observed resident (33) by licensed practical nurse (LPN) (K,) and sodium chloride (a medication to treat low sodium levels in the blood) was administered on time for one of one observed resident (23) by LPN (K). Those observed errors resulted in a medication error rate of 6.9%. Findings include: 1. Observation and medication administration record (MAR) review on 7/8/26 at 4:02 p.m. with LPN K during resident 23's medication administration revealed that she administered two tablets of sodium chloride 1000 milligrams (mg) at 4:02 p.m. She did not document that the sodium chloride was administered. The sodium chloride was scheduled to be administered at 6:00 p.m. 2. Review of resident 23's electronic medical record (EMR) revealed he admitted to the facility on 2/6/25. He had a 12/23/25 physician's order for sodium chloride 2,000 milligrams (mg), to be given by mouth three times per day. The medication was scheduled to be administered daily at 8:00 a.m., 12:00 p.m., and 6:00 p.m. 3. Observation, interview, and MAR review on 7/8/26 at 4:29 p.m. with LPN K while she prepared and	F0759	F759 Free of Medication Error Rts 5 percent or more Residents 33, and 23 had no identified negative outcomes resulting in observation and medication administration resulting in a medication error rate of less than 5 percent and the medication error rate of 6.9 percent. All residents had the potential to be affected by this finding. LPN K provided immediate re-education on 7/9/26 regarding proper handling of hazardous medications, and proper medication administration by DON. Hazardous medications and medication administration policies revised on 7/30/26. LPN K 1:1 education done on 7/30/26 after revision of policies. DON provided re-education on the medication administration policy with all nurses and medication aides on 7/31/26. All nurses or medication aids who have were not re-education will be educated before their next scheduled shift. DON or designee will audit medication administration weekly x 4 weeks then monthly x3 months until substation compliance is met. The DON and/or designee will submit audit findings to QA/QAPI Committee. The audit findings will be reviewed with further recommendations as needed to ensure compliance.	8/2/2026

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F0759 SS = D	Continued from page 7 administered resident 33's Flomax (a medication used to treat symptoms of an enlarged prostate) revealed LPN K removed a Flomax 0.4 milligram (mg) capsule from the medication bubble package (a tool that organizes pills by the day and time) into her bare hand and placed that capsule on a tissue on the medication cart. With her bare hands, she opened the Flomax capsule and placed the contents of that capsule into a medication cup with resident 33's other crushed medications with applesauce. She mixed all the medications together in apple sauce. She then administered those medications to resident 33. The banner on the top of the MAR stated, "DO NOT CRUSH or OPEN Tamsulosin [Flomax] capsules." The Flomax 0.4 mg was scheduled to be administered at 2:00 p.m. It was documented in resident 33's MAR that it had already been administered. LPN K verified resident 33's Flomax was scheduled to be administered at 2:00 p.m. and it was documented that it was already administered. LPN K stated she was the person who documented the Flomax was administered but did had not administer it at 2:00 p.m. LPN K stated that medications were to be administered within one hour before or one hour after the scheduled administration time. 4. Review of resident 33's EMR revealed he admitted to the facility on 11/27/07. He had a 12/25/25 physician's order for Flomax 0.4 mg, one capsule to be administered daily. The Flomax was scheduled to be administered at 2:00 p.m. The physician's order in resident 33's EMR stated, "DO NOT CRUSH or OPEN." 5. Interview on 7/9/26 at 1:17 p.m. with director of nursing (DON) B revealed that the consultant pharmacist reviewed all the residents' medications and determined which medications could be crushed or opened. She expected that if the banner on the resident's MAR indicated a medication was not to be crushed or opened, the staff would not crush or open that medication. Medications were to be administered within one hour before or after the scheduled administration time. She expected medications to be documented as administered immediately after they were administered to the resident. 6. Review of the provider's 12/21/25 Medication	F0759		

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F0759 SS = D	Continued from page 8 Administration policy revealed "Ensure that the six rights of medication are followed: Right resident, Right drug, Right dosage, Right route, Right time, Right documentation." "Administer within 60 minutes prior to or after scheduled times unless otherwise ordered by [the] physician." "Crush medications as ordered. Do not crush medications with 'do not crush' instructions." 7. Review of the provider's 1/9/26 Medication Errors policy revealed, "The facility must ensure that it is free of medication error rates of 5% [percent] or greater as well as significant medication error events." "The facility will consider factors indicating errors in medication administration, including but not limited to, the following: Medications administered not in accordance with the prescriber's order. Examples include, but not limited to: Incorrect dose, route of administration, dosage form, time of administration." "Medication administration not in accordance with the manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological. Examples include, but not limited to: ...Crushing 'do not crush' medications."	F0759		
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;	F0880	F880 Infection Prevention & Control All residents have the potential to be affected by this finding. No Negative effects were identified as result of the observation of staff following standard infection prevention and control practices done by CNA J and CNA E who did not perform hand hygiene before and after glove use while providing personal cares for resident 2. DON re-educated CNA J and CNA E on 7/11/26 with proper hand hygiene and glove use. Re-education on proper hand hygiene and glove use was provided again with identified CNA J and CNA Eon hand hygiene policies, competencies, and glove use on 7/29/26 and 7/30/26. Re-education of hand hygiene policies glove use, and competencies started with All Staff on 7/29/26 the re-education is ongoing and all staff members will be re-educated before their next shift. The IP Nurse and/or designee will audit handwashing and glove use on nursing staff weekly x4 weeks, monthly x3 months and/or until substantial compliance is met. The IP Nurse will submit audit findings to QA/QAPI for review/recommendations as needed to ensure compliance.	8/2/2026

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F0880 SS = D	Continued from page 9 §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 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,	F0880		

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	43A089	A. BUILDING B. WING	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White River Health Care Center	515 E 8TH STREET POST OFFICE BOX 310, WHITE RIVER, South Dakota, 57579

(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 10 the provider failed to ensure the staff followed standard infection prevention and control practices by one of one observed contracted travel certified nursing assistant (CNA) (J), and one of one observed CNA (E) who did not perform hand hygiene before and after glove use while providing personal cares for one of one sampled resident (2). Findings include: 1. Observation on 7/7/26 at 4:08 p.m. in resident 2's room of LPN D, contracted travel CNA J, and CNA E providing personal cares for resident 2 revealed resident 2 was incontinent (involuntary urine or bowel leakage) of bowel. LPN D and contracted travel CNA J each put on a gown, performed hand hygiene, and put on a pair of gloves. LPN D positioned resident 2 onto his right side. Contracted travel CNA J removed the resident's soiled incontinence brief, and cleansed resident 2's buttocks and genitals with disposable cleansing cloths. LPN D put a clean brief on the resident. Contracted travel CNA J removed her soiled pair of gloves and discarded them in the garbage can, did not perform hand hygiene, put on a clean pair of gloves, and removed the soiled absorbent bed pad from under resident 2. LPN D wiped resident with disposable cleansing cloths, removed her gloves, discarded them in the trash can, and performed hand hygiene. Contracted travel CNA J the removed her gown and gloves, discarded them in the trash can, and did not perform hand hygiene. With her uncleaned hands, contracted CNA J removed the trash bag with the soiled cleansing cloths and soiled brief in it, put a new trash bag in the garbage can, and exited the room with the garbage bag of soiled items. LPN D remained in resident 2's room until CNA E entered the room with a clean absorbent bed pad. CNA E performed hand hygiene, put on a gown and a pair of gloves, and assisted LPN D to put the absorbent bed pad under resident 2. CNA E removed her gown and gloves, discarded them in the garbage can, did not perform hand hygiene, and exited resident 2's room. LPN D removed her gown and gloves, discarded them in the garbage can, performed hand hygiene, and exited resident 2's room. 2. Interview on 7/9/26 at 12:45 p.m. with LPN D revealed hand hygiene was to be completed when the staff entered a resident's room, before leaving a resident's room, before gloves were put on, and	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING B. WING	07/09/2026

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White River Health Care Center	515 E 8TH STREET POST OFFICE BOX 310, WHITE RIVER, South Dakota, 57579

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F0880 SS = D	Continued from page 11 after gloves were removed. 3. Interview on 7/9/26 at 1:17 p.m. with director of nursing (DON) B revealed she expected the staff to wear gloves anytime they touched something that could potentially be contaminated, or anytime there was potential for contact with bodily fluids. She expected the staff to use alcohol-based hand sanitizer before they put on gloves and after they removed the gloves. If the staff's hands were visibly soiled, then she expected the staff to use soap and water to perform hand hygiene. The staff were to perform hand hygiene before and after providing resident cares. 4. Review of the provider's 4/26/22 Handwashing/Hand Hygiene policy revealed "This facility considers hand hygiene the primary means to prevent the spread of infections." "Use an alcohol-based hand rub containing at least 62% [percent] alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...Before and after direct contact with residents; ...Before moving from a contaminated body site to a clean body site during resident care; After contact with a resident's intact skin; After contact with blood or bodily fluids; ...After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; After removing gloves." 5. Review of the provider's 4/24/22 Personal Protective Equipment-Using Gloves policy revealed, "The use of gloves will vary according to the procedures involved. The use of disposable gloves is indicated: ...When handling soiled linen or items that may be contaminated."	F0880		

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
	10710	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(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 7/7/26 through 7/9/26. White River Health Care Center was found not in compliance with the following requirement: S206.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs.	S 206	S206 Personnel Training All residents have the potential to be affected by these findings. No residents were affected by this finding. Housekeeper L started training modules on 7/10/26. All training modules identified not completed fire prevention/response, emergency preparedness/ procedure, accident prevention, safety procedures, resident rights, confidentiality of resident information, dining assistance, nutritional risks, and hydration were all completed by 7/19/26. Administrator and/or designee revised policy as of 7/10/26 re-educated Housekeeper L and Housekeeping Supervisor G on Training and Orientation. A staff development training plan is put into place 7/29/26 to track all new hire and annual training required. Administrator and/or designee will audit Relias monthly until substantial compliance is met. The findings will be submitted to QA/QAPI for review/ recommendations as needed to ensure compliance.	08/02/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 8/2/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10710	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 206	Continued From page 1 This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure the mandatory orientation training was completed within thirty days of hire for one of one newly hired employee (L). Findings include: 1. Review of housekeeping L's employee record revealed he was hired on 1/26/26. He did not complete the training modules for fire prevention/response, emergency preparedness/procedures, accident prevention, safety procedures, resident rights, confidentiality of resident information, dining assistance, nutritional risks, and hydration within 30 days of his hire date. 2. Interview on 7/9/26 at 1:22 p.m. with administrator A revealed that the department supervisors were "usually" responsible for monitoring their staff's new hire orientation training. She acknowledged that the facility lacks a consistent, coordinated process to track employee training and that the department supervisors, herself, and the business office staff "try to keep track of the [employees'] trainings." 3. Interview on 7/9/26 at 2:14 p.m. with the housekeeping supervisor G revealed she initiated the new hire orientation training modules but did not have access to Relias (an online learning and compliance platform designed specifically for healthcare and human services organizations) to monitor if the new employee's training was completed. Administrator A and the business office staff would track the employees' training and inform housekeeping supervisor G when the	S 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10710	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

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S 206	Continued From page 2 housekeeping staff needed to complete the required orientation training and any additional training modules. 4. Review of the provider's December 2001 Staff Development Program policy revealed that "All personnel must participate in [the] initial orientation and regularly scheduled in service training classes."	S 206		

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
	43A089	A. BUILDING 01 - MAIN BUILD... B. WING	07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White River Health Care Center	515 E 8TH STREET POST OFFICE BOX 310, WHITE RIVER, South Dakota, 57579

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 7/7/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. White River Health Care Center 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
Marilla F Hodges	administrator	8/2/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 7/7/26. White River Health Care Center 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
Michelle Hodges	Administrator	8/2/2026