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

| **STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS** | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435086** | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED **06/02/2026** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **RIVERVIEW HEALTHCARE CENTER** | **611 EAST 2ND AVE , FLANDREAU, South Dakota, 57028** |

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| F0000 | INITIAL COMMENTS<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/1/26 through 6/2/26. Areas surveyed included accident hazards related to a resident elopement and a resident starting a fire in his room, and quality of care related to prompt responses to emergent resident medical needs. Riverview Healthcare Center was found not in compliance with the following requirement: F755. | F0000 | 1) Corrective action taken on May 28th, 2026. DON was granted access by Regional Nurse to RxNow, the emergency medicine system. All nurses on schedule during this event were then granted access to RxNow on May 28, 2026 (print proof). All other residents are at risk of not receiving medication on the day of admission if nurses do not have access to RxNow system. Nurse will validate admission medication documentation to actual medication from Pharmacy for all new admission to ensure all medications ordered are received.<br>2) Nurses will be granted access by nurse leadership to RxNow prior to start of next shift and education regarding RxNow as well as expectation of validating new admission medication delivery.<br>3) DON/designee will audit RxNow access and pharmacy deliveries via manifestation, weekly for 4 weeks and bimonthly for 1 month and monthly for 4 months. Results of these audits will be brought to monthly QAPI meeting for review and recommendation<br>4) Date of Compliance June 18, 2026 | 6/18/26 |
| F0755<br>SS = D | Pharmacy Srvcs/Procedures/Pharmacist/Records<br><br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br><br>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.<br><br>§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.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§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 | F0755 | | |

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 |
|---|---|---|
| Coleen McCarty | Administrator | 6/18/2026 |

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| F0755<br>SS = D | Continued from page 1<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, observation, and policy review, the provider failed to ensure two of two registered nurses (RNs) (D and J) had access to the emergency medication kit (e-kit) for one of one sampled resident (1) who subsequently did not receive his antipsychotic medication (a drug that alters specific brain activities to reduce symptoms of mental health conditions) and hallucinated and started a fire in his bedroom. Certified nursing assistant (CNA) K and RN J extinguished the fire, and no residents were injured as a result of the fire.<br><br>Findings include:<br><br>1. Review of the provider’s 5/27/26 SD DOH FRI revealed that at approximately 5:00 a.m. on 5/27/26, staff found resident 1 in his room with a lighter after a small fire ignited and damaged a plastic water mug, part of his mattress, and his bed linens. Resident 2, resident 1’s roommate, had alerted the staff, who quickly extinguished the fire with water and evacuated nearby residents until the fire department cleared the area. Emergency medical services (EMS) assessed both residents. Resident 1 was evaluated at the clinic and admitted to the hospital for observation, while his roommate declined further evaluation. Resident 1’s family was notified, the lighter was removed, and his care plan (a personalized plan that addresses a resident’s care needs, goals, and interventions) was reevaluated upon his return to the facility.<br><br>2. Review of resident 1’s electronic medical record (EMR) revealed that he admitted to the facility from the hospital on 5/26/26.<br><br>His 5/26/26 hospital referral packet indicated resident 1 was treated for delirium (sudden, severe confusion with trouble focusing and awareness). His doctor prescribed 2.5 milligrams (mg) of olanzapine, an antipsychotic medication, in the morning, and 7.5 mg of olanzapine at bedtime to treat his delirium. On 5/26/26, he received his morning dose of olanzapine at 7:35 a.m. at the hospital before he discharged from the hospital to the nursing facility. His 5/26/26 hospital discharge orders indicated he was to continue taking the morning and bedtime doses of | F0755 | | |

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| F0755 SS = D | Continued from page 2<br>olanzapine.<br><br>A note categorized as “Orders – Administration Note” was entered on 5/26/26 at 9:34 p.m. that read, “New admit awaiting meds.”<br><br>Throughout the night on 5/26/26 and into the early morning of 5/27/26, resident 1 was attempting to get out of bed by himself. He was given 2 mg of lorazepam (a medication used to treat anxiety), at around 12:10 a.m. on 5/27/26.<br><br>A nursing progress note from 5/27/26 at 2:06 a.m. read, “[resident 1] was found with bed pushed away from the wall and was attempting to climb out of bed. CNA’s [Certified nursing assistants] assisted resident back into bed.” The lorazepam medication was marked as “effective” on 5/27/26 at 4:40 a.m.<br><br>A note categorized as “Communication with Family…” was entered on 5/27/26 at 6:41 a.m. that read, “Resident's son [was] made aware of fire started this [morning] by resident. Let him know EMS [emergency medical service] checked him over and that there were reports of hallucinations at the time. [Resident 1’s son] stated that he was having those [hallucinations] in the hospital as well…”<br><br>A nursing progress note written by contracted travel RN J on 5/27/26 at 7:09 a.m. read, “At [5:00 a.m.], This nurse heard CNA yelling down [the] hallway. This nurse went down [the] hallway and walked into [the] resident’s room to find soaker pad [an incontinence product, relating to involuntary urine or bowel leakage] and [bed] sheet on the floor on fire. As well as [the] mattress on fire with [resident 1] sitting near it. CNA grabbed [roommate’s] water jug and dumped it on the bed. This nurse put out sheets on the floor. Room was filled with smoke. Got resident in his] wheelchair and out of [the] room.” RN J assessed resident 1 and did not find any skin injuries or burns.<br><br>A nursing progress note written by contracted travel RN J on 5/27/26 at 7:36 a.m. read, “Called [telehealth, an electronic remote health service] to get a [one-time] dose for olanzapine [7.5 mg] instead of the [2.5 mg] due to [the] resident missing [a] dose last night due to pharmacy not bringing [the olanzapine]…”<br><br>3. Interview on 6/1/26 at 11:42 a.m. with resident 2 revealed that he was resident 1’s roommate and witnessed the fire on the morning of 5/27/26. He explained that resident 1 admitted to the facility on the evening of 5/26/26. Resident 2 stated that | F0755 | | |

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| F0755<br>SS = D | Continued from page 3<br>throughout the night on 5/26/26, resident 1 appeared anxious and verbalized that he wanted to go out to smoke. Resident 2 awoke early in the morning to a noise and saw resident 1 “playing in the fire.” He yelled for the staff, who came to their room right away and extinguished the fire.<br><br>4. Interview on 6/1/26 at 2:34 p.m. with resident 1 revealed that he did not remember starting the fire or much from that night. He said, “Apparently, I was hostile, but I don’t remember. I was pretty mad, mad at the world. I don’t know if I was dreaming.”<br><br>5. Review of the police department’s report regarding the early morning fire on 5/27/26 revealed, “when asked who else was in the room, [resident 1] stated that [four] adult males were also in his room, along with his roommate [resident 2]. [The officer] spoke to [resident 2], who stated that [resident 1] had used the lighter to start a fire. [Resident 2] stated that only [resident 1] and [resident 2] were in the room at the time. …At this time, [the officer] cannot determine if the fire was intentional. [Resident 1] appeared to not understand how the fire started, and indicated in his statements about who else was in the room, that he was possibly hallucinating.”<br><br>6. A phone interview with resident 1’s family member and responsible party was attempted throughout the survey, but the calls were not answered. There was no ability to leave a voicemail message for a return call, as the family member’s phone voicemail box was full.<br><br>7. Phone interview on 6/2/26 at 7:38 a.m. with contracted travel RN J revealed that resident 1 admitted to the facility late in the evening on 5/26/26 and the pharmacy did not deliver a supply of his bedtime dose of olanzapine to the facility. Olanzapine, both 2.5 mg and 7.5 mg, was available in the emergency medication kit (e-kit), but neither she nor RN D had access to unlock the e-kit. She called the telehealth provider early in the morning on 5/27/26 for an increased dose of resident 1’s olanzapine because he hallucinated during the night and started a fire in his bedroom. Another nurse with access to the e-kit was present at that time and obtained the olanzapine from the e-kit and administered it to resident 1. She started working at the facility at the end of March 2026, and director of nursing (DON) B gave her a login username and password to access medications in the e-kit on Friday 5/29/26.<br><br>8. Interview on 6/2/26 at 3:14 p.m. with contracted | F0755 | | |

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| F0755 SS = D | Continued from page 4<br>travel licensed practical nurse (LPN) I revealed that he started his contract at the facility on 5/25/26. He did not have access to the e-kit until Friday 5/29/26.<br><br>9. Observation and interview on 6/2/26 at 3:23 p.m. with RN E in the medication room revealed there was a tall gray cart with multiple locked drawers. There was a computer on top of the cart and a fingerprint scanner. She explained that the cart was their e-kit. She believed the contracted travel nurses were not supposed to have access to the e-kit. She confirmed that olanzapine was available in the e-kit in 2.5 mg and 5 mg tablets.<br><br>10. Interview on 6/2/26 at 3:45 p.m. with administrator A and director of nursing (DON) B revealed that resident 1 was a “late admit.” He arrived at the nursing home between 4:00 and 5:00 p.m. on 5/26/26. When residents admitted to the nursing home from the hospital, their medication orders were to be faxed to the pharmacy. Social services assistant (SSA) C was responsible for faxing the residents’ medication orders to the pharmacy. If a resident was scheduled to receive a medication that was not delivered to the facility yet, DON B expected the nurses to obtain that medication from the e-kit to administer to the resident. She expected the nurses to call a nurse manager if they did not have access to the e-kit. DON B said that LPN G would have been available to go to the facility to unlock the e-kit for RNs D and J.<br><br>Administrator A and DON B identified that not all licensed nurses had access to the e-kit after resident 1’s fire-starting incident on the morning of 5/27/26. At that time, DON B did not have the capability to grant other nurses access to the e-kit. Once administrator A and DON B contacted the corporate office and DON B gained that capability, DON B started granting access to the e-kit to all licensed nurses on staff on 5/29/26.<br><br>11. Review of the provider’s e-kit instruction manual revealed that a person with an administrator’s account had to log into their profile to add new employees to the system to grant access to the e-kit.<br><br>12. Review of the provider’s January 2025 Emergency Pharmacy and Emergency Kits (E-Kits) policy revealed that “emergency needs for medication are met by using the nursing care center’s approved emergency medication supply or by special order from the provider pharmacy.” | F0755 | | |

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FORM APPROVED
OMB NO. 0938-0391

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| F0755<br>SS = D | Continued from page 5<br><br>“When an emergency or stat [immediate] medication is needed, the nurse first verifies and reviews the prescriber’s orders for appropriateness, checks the resident’s allergies, and removes the required non-controlled medication from the emergency kit. Emergency medications are only administered with a valid prescriber’s order.”<br><br>13. Review of the provider’s November 2016 Admission policy revealed the policy did not contain instructions or guidance related to the process of receiving new resident physicians’ orders or obtaining a resident’s medications before admitting to the facility. | F0755 | | |