

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

PRINTED: 04/02/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/25/25 through 3/27/25. White River Health Care Center was found in compliance.</p> <p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/25/25 through 3/27/25. The area surveyed was the potential for resident neglect related to staff insubordination. White River Health Care Center was found in compliance.</p>	F 000			

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

Mandi F. Hodges

TITLE

Administrator

(X6) DATE

4/11/25

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.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/25/25 through 3/27/25. White River Health Care Center was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on 3/25/25 through 3/27/25. White River Health Care Center was found not in compliance with the following requirement: S430.	S 000		
S 430	44:73:12:27(1-3) Ventilating Systems The facility's ventilating systems must meeting the following requirements: (1) All occupied areas of the building must maintain a minimum humidity level of fifteen percent relative humidity provided through the building central ventilation system; (2) Beauty shops must provide a minimum of fifteen air changes per hour of exhaust ventilation when the room is in use; and (3) Toilet and bathing rooms must provide a minimum of ten air changes per hour of exhaust ventilation. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in one location (public restroom by the nurses' station). Findings include:	S 430	S430 Ventilating Systems All Residents had the potential to be affected, however they were not affected. The administrator did training on the HVAC systems with the policy emphasizing the importance of maintenance and repairs to the HVAC System to the maintenance supervisor on 04/11/2025. The maintenance supervisor will do audits on the HVAC system and inform the administrator when system needs repair and call for repairs and follow-up when needed. Maintenance Supervisor will audit weekly to ensure ventilation systems are working properly. The administrator will review audits monthly for the first six months and as needed after compliance is met. Will be reviewed at QA/QAPI monthly for six months or until substantial compliance is obtained.	04/11/2025

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

Bonnie F. Hodges

TITLE

Administrator

(X6) DATE

4/11/25

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 430	<p>Continued From page 1</p> <p>1. Observation and testing on 3/25/25 at 10:00 a.m. revealed the exhaust ventilation for the public restroom at the nurses' station was not functioning.</p> <p>Interview with the administrator at that same time confirmed that finding. She stated the exhaust fan served several different rooms. She stated a quote was being obtained from a contractor to repair the exhaust fan.</p>	S 430		