PRINTED: 01/22/2025 FORM APPROVED OMB NO. 0938-0391

A 143086  IN MING OF PROVIDER OR SUPPLIER  RIVERVIEW HEALTHCARE CENTER  STREET ADDRESS, CITY, STATE, 2IP CODE  ## LEAST 2ND AVE FLANDREAU, SD 57028  SUMMARY STATEMENT OF DEHICIPACIES  SUMMARY STATEMENT OF DEHICIPACIES  SUMMARY STATEMENT OF DEHICIPACIES  BEACH DEPICIPACY DIVIS TO PERIODE OF YULL REGULATORY OR LSG IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  An extended complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 16/25 through 16/25. Areas surveyed included accident hazards related to a resident elopement, allegations of physical, verbal, and sexual abuse by staff members, and violations of resident privacy rights. Riverview Healthcare Center was found not in compliance with the following requirements: F583, F600, F609, F610, and F835.  On 1/6/25 at 8.30 p.m., immediate jeopardy was identified related to staff-to-resident abuse at F600. On 1/7/25 at 12.56 p.m., the removal plan was accepted with agreed upon changes made by the provider. Immediacy was removed on 1/7/25 at 4.30 p.m. after onsite review.  On 1/8/25 at 8.35 p.m., two additional immediate jeopardies were identified related to failure to investigate/correct/prevent alleged abuse at F610. On 1/8/25 at 4.30 p.m., two removal plans were provided and accepted for F609 and F610. The immediacy was removed after receipt and onsite review of the provider's accepted removal plans on 1/8/25. As part of the onsite review, it was determined the 7/7/25 12/56 p.m. accepted plan included reporting the alleged abuse to the required entities, and investigating the alleged abuse to a thorough extent.  The census was 62.  F583 Personal Privacy/Confidentiality of Records  F583 See next page		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		STRUCTION		PLETED
The case of Provider on Supplier RIVERVIEW HEALTHCARE CENTER  RIVERVIEW HEALTHCARE CENTER HAVE SECURITING AND CORRECTION RECORDING TO COMPUTE ACTION SHOULD BE CANCESCENCE IT O. THE APPROPRIATE CONCESS ARE PERSONAL FOR THE APPROPRIATE CONCESS ARE PERSONAL FOR THE APPROPRIATE CONCESS AND CONCULCED TO THE APPROPRIATE CONCESS ARE PERSONAL FOR THE APPROPRIATE CONCESS AND CONCULCED TO THE APPROPRIATE CONCESS AND CONCESS ARE PERSONAL FOR THE APPROPRIATE CONCESS AND CONCESS AND CONCESS AND CONCESS ARE PERSONAL FOR THE APPROPRIATE CONCESS AND CONCE			435086	B. WING _				
FREETX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FOOD  INITIAL COMMENTS  An extended complaint health survey for compliance with 42 CFR Part 483, Subpart 8, requirements for Long Term Care facilities was conducted from 1/6/25 through 1/8/25. Areas surveyed included accident hazards related to a resident elopement, allegations of physical, verbal, and sexual abuse by staff members, and violations of resident privacy rights. Rilverview Healthcare Center was found not in compliance with the following requirements: F583, F600, F609, F610, and F835.  On 1/8/25 at 8:30 p.m., immediate jeopardy was identified related to staff-to-resident abuse at F600. On 1/7/25 at 12:50 p.m., removal plan was provided to the South Dakota Department of Health. On 1/7/25 at 12:50 p.m., the removal plan was accepted with agreed upon changes made by the provider. Immediacy was removed on 1/7/25 at 4:30 p.m., who removal plans were provided and accepted for F609 and F610. The immediacy was removed after receipl and onsite review of the provider's accepted removal plans on 1/8/25. As part of the onsite review, it was determined the 1/7/25 1:256 p.m. accepted plan included reporting the alleged abuse to the required entities, and investigating the alleged abuse to a thorough extent.  The census was 62.  Personal Privacy/Confidentiality of Records  F583  See next page			ER		611 EA	ST 2ND AVE		
An extended complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 16/25 through 18/25. Areas surveyed included accident heards related to a resident elopement, allegations of physical, verbal, and sexual abuse by staff members, and violations of resident privacy rights. Riverview Healthcare Center was found not in compliance with the following requirements: F583, F600, F609, F610, and F835.  On 1/6/25 at 8:30 p.m., immediate jeopardy was identified related to staff-to-resident abuse at F600. On 1/7/25 at 10:30 a.m., a removal plan was provided to the South Dakota Department of Health. On 1/7/25 at 10:30 p.m., the removal plan was accepted with agreed upon changes made by the provider. Immediacy was removed on 1/7/25 at 4:30 p.m., after onsite review.  On 1/8/25 at 3:57 p.m., two additional immediate jeopardies were identified related to failure to report alleged abuse at F600 and failure to investigate/correct/prevent alleged abuse at F610. On 1/8/25 at 4:30 p.m., two removal plans were provided and accepted for F609 and F610. The immediacy was removed after receipt and onsite review of the provider's accepted removal plans on 1/8/25, As part of the onsite review, it was determined the 1/7/25 12:56 p.m. accepted plan included reporting the alleged abuse to the required entities, and investigating the alleged abuse to a thorough extent.  The census was 62.  F 583  Personal Privacy/Confidentiality of Records  F 583  See next page	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	N SHOULD BE E APPROPRIATE	
compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/6/25 through 1/8/25. Areas surveyed included accident hazards related to a resident elopement, allegations of physical, verbal, and sexual abuse by staff members, and violations of resident privacy rights. Riverview Healthcare Center was found not in compliance with the following requirements: F583, F600, F609, F610, and F835.  On 1/6/25 at 8:30 p.m., immediate jeopardy was identified related to staff-to-resident abuse at F600. On 1/7/25 at 10:20 a.m., a removal plan was provided to the South Dakota Department of Health. On 1/7/25 at 10:25 p.m., the removal plan was accepted with agreed upon changes made by the provider. Immediacy was removed on 1/7/25 at 4:30 p.m., after onsite review.  On 1/8/25 at 3:37 p.m., two additional immediate jeopardies were identified related to failure to report alleged abuse at F600 and failure to investigate/correct/prevent alleged abuse at F610. On 1/8/25 at 4:30 p.m., two removal plans were provided and accepted for F609 and F610. The immediacy was removed after receipt and onsite review of the provider's accepted removal plans on 1/8/25. As part of the onsite review, it was determined the 1/7/25 12:56 p.m., accepted plan included reporting the alleged abuse to the required entities, and investigating the alleged abuse to a thorough extent.  The census was 62.  F 583  Personal Privacy/Confidentiality of Records  F 583  See next page	F 000	INITIAL COMMENTS		FC	00			
F 583 Personal Privacy/Confidentiality of Records F 583 See next page		compliance with 42 Orequirements for Long conducted from 1/6/2 surveyed included acresident elopement, a verbal, and sexual abviolations of resident Healthcare Center was with the following req F609, F610, and F83 On 1/6/25 at 8:30 p.n. identified related to si F600. On 1/7/25 at 10 was provided to the SHealth. On 1/7/25 at was accepted with act by the provider. Immed 1/7/25 at 4:30 p.m. at On 1/8/25 at 3:57 p.m. jeopardies were identified abuse investigate/correct/pr F610. On 1/8/25 at 4:30 were provided and act The immediacy was a onsite review of the plans on 1/8/25. As p was determined the 1 plan included reportir required entities, and	FR Part 483, Subpart B, g Term Care facilities was 5 through 1/8/25. Areas cident hazards related to a allegations of physical, buse by staff members, and privacy rights. Riverview as found not in compliance uirements: F583, F600, 5.  In, immediate jeopardy was taff-to-resident abuse at 0:20 a.m., a removal plan couth Dakota Department of 12:56 p.m., the removal plan greed upon changes made ediacy was removed on a feer onsite review.  In, two additional immediate tified related to failure to at F609 and failure to event alleged abuse at 30 p.m., two removal plans are provider's accepted removal art of the onsite review, it 1/7/25 12:56 p.m. accepted ag the alleged abuse to the investigating the alleged					
	F 583		nfidentiality of Records	F 5	83 See	e next page		

Lourdes Parker Exec

Executive Director

1/31/2025

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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		435086	B. WING			08/ <b>2025</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	00/2023
				611 EAST 2ND AVE		
RIVERVIE	W HEALTHCARE CENTE	:R		FLANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 583 SS=D	CFR(s): 483.10(h)(1)- §483.10(h) Privacy ar The resident has a rig confidentiality of his or records.  §483.10(h)(l) Persona accommodations, me telephone communica and meetings of famil this does not require to private room for each  §483.10(h)(2) The fact residents right to persoright to privacy in his written, and electronic the right to send and mail and other letters, materials delivered to including those delive than a postal service.  §483.10(h)(3) The resident has the of personal and medic provided at §483.70(h) federal or state laws. (ii) The facility must a Office of the State Lot to examine a resident administrative records law.	nd Confidentiality. In the personal privacy and or her personal and medical all privacy includes dical treatment, written and ations, personal care, visits, y and resident groups, but the facility to provide a resident.  It is in the personal care, visits, y and resident groups, but the facility to provide a resident.  It is in the personal care, visits, y and resident groups, but the facility to provide a resident.  It is in the personal care, visits, y and resident groups, but the facility for provide a resident.  It is in the personal and medical records.  It is in the personal privacy including the promptly receive unopened a packages and other the facility for the resident, ared through a means other sident has a right to secure onal and medical records.  It is in the personal privacy and medical records.  It is in the personal privacy and medical records.	F 58	· ·	g using intified  d using staff two A and oring the committee	1/25/2025
		ota Department of Health intake review, interview,				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		435086	B. WING			01/	08/2025
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER		61	TREET ADDRESS, CITY, STATE, ZIP CODE I1 EAST 2ND AVE LANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 583	failed to uphold a resiprivacy for at least 3 due to anonymous state cellphone to secretly conversations. Findings include:  1. Review of the SD I dated 12/31/24 reveal *The SD DOH received detailing allegations of assistant (CNA) J. *The sender explaine audio recordings of periodical recordings of resident recordings of resident she denied any manager to the total state of the care that CNA J we *While anonymous staff mentioned the conversations "for evidence to present to *Anonymous staff mentioned the conversations "for evidence to present to *Anonymous staff mentioned the conversations of residents anonymous staff mentioned the conversations "for evidence to present to *Anonymous staff mentioned the conversations of residents anonymous staff mentioned the conversations of residents and the conversations of the	d policy review, the provider dent's right to personal of 62 residents (1, 3, and 6) aff member M using their record private resident  DOH complaint intake form led: ed an email on 12/27/24 of abuse by certified nursing d that there were several rivate resident conversations by mentioned audio at 1 and 6.  The at 5:28 p.m. with director of the allegations revealed ecent allegations of abuse or with anonymous staff member M was concerned with was providing.  The affirmed was talking to buse they were allegedly ed their cellphone to the residents were saying. The administration.  The administration in the administration in the same of t	F	583			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
		435086	B. WING_			C
	ROVIDER OR SUPPLIER W HEALTHCARE CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	l	01/08/2025
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 583	about the above alle *He initially denied to him recently with other staff. *When asked more specific incidents, he "had come in and satalk to her [CNA J], s *He explained that the nondescript things a what CNA J was doi *ED A did not mention recordings.  5. Interview on 1/7/2 director of clinical opabove information re *She expected all rebe taken seriously a including reporting to launching a thorough the abuse and negle *Anonymous staff mesuspension pending secretly recording resident the Federal Health I Accountability Act (Hof conduct, and the extra required anondetermine who they the recordings from the recordings from all conducts and the recordings from the recordings from all conducts and the recordings from the recordings from all conducts and the recordings from all conducts and the recordings from the recordings from all conducts and the recordings from all conducts are recordings from all conducts and the recordings from all conducts are recording from all conducts a	tremember when.  25 at 6:30 p.m. with ED A agations revealed: that any staff members came allegations of abuse against apointed questions about the confirmed a staff member aid, 'Well I think you should she is being rough."  The staff member was giving and could not describe exactly ang. The anything about the audio anything about the audio aports of suspected abuse to any thing about the evealed: ports of suspected abuse to any thing about the required entities and the investigation according to the extending to the required entities and the investigation related to the extending to the extend	F 5	83		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER.		6	TREET ADDRESS, CITY, STATE, ZIP CODE  11 EAST 2ND AVE  LANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 583	ED A about the allegation in the voice recordings that had made.  *Anonymous staff me staff member M] was conversations out of the totry to get proof become to try to get proof the prove to the prove	mber N was with nber M when they went to ations of abuse. mber N was aware of the anonymous staff member M mber N said, "[Anonymous n't recording the malice, [they were] doing it ause [they don't] believe that [it]." mber N confirmed that the ed with ED A. mbers M and N went to ED on 12/30/24 around  ider's March 2012 CNA Job ne CNA is expected to apliance with state and ider's September 2023 revealed: Ethics. Ethical integrity is the ons, guiding us to make ent, and morally sound efit of our patients, staff, and esident Rights section:	F	583			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		435086	B. WING			·	08/2025
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	00/2025
RIVERVIE	W HEALTHCARE CENTE	ER			11 EAST 2ND AVE CLANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 583	Conduct section: "To promptly and efficient establish and maintai excellence in healthcaresidentsthe follow established1. Employees are ex [company's] Code of10. Employees will Executive Director an abuse or neglect d shall be protected wh -11. Employees will a standards of the high and behavior." *Starting on page 58: forth examples of cordisciplinary action, incomployment:12. Resident abus misappropriation of reference in the conduct of an whether verbal, ment24. Conduct of an whether verbal, ment29. Immoral, inappronduct" *Starting on page 75, Smart Phones, Table: Devices section: -"Employees arepr handheld devices for working hours except -Employees are not a handheld devices in redirect care staff is product c	under the Standards of meet resident's needs dy, our mission is to not the highest standards of are. To protectits ing standards have been pected to comply with the Conduct.  Il immediately report to the sy of the following: resident ishonesty Confidentiality enever possible. dhere to positive ethical est level in communication  "The following listsets aduct that will result in cluding possible termination are or neglect or esident property. alth or safety rules applying employees. abusive or harassing nature all or physical. Propriate, or indecent under the Cell Phones, its, & Other Handheld ohibited from using personal purposes during	F	583			

· ,	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		435086	B. WING			C <b>01/08/2025</b>
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	l	01/08/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 583	-Employees may not manner that violates -Recording Devices our premises and significant programments and significant provides and resignificant provides and resignificant provides and resignificant provides and resignificant provides and responsible and responsible, transpart decisions for the beautificant provides and responsible a	ot use a handheld device in a sany other Company policy.  : To maintain the security of systems, and the privacy of our dents, the Company prohibits graphy and audio or video doyees, confidential lents.  Cludes the use of handheld dith cameras and audio and abilities."  Ovider's 2023 Code of Conduct of Ethics. Ethical integrity is the extions, guiding us to make arent, and morally sound nefit of our patients, staff, and ed Persons and Covered export suspected violations ting Process as well as eral, state and local reporting empany's] policies."  Tymous staff member M's led:  Cknowledgement and a 8/3/24 indicating they eccipt of a copy of the lock, as well as their acceptance of the contents	F 58	33		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		435086	B. WING		C 01/08/2025
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	:R	•	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	, 0.0012020
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F 583	*Her hire date was 10 *She was trained on a topics on 10/2/23, included abuse prohibition.  12. Review of anonyremployee file reveale the required training the resident rights and abuse 13. Review of the professecutive Director job *"Essential Functions -4. Compliance Management of the professes of the professe	s personnel file revealed: 0/1/23. All the required training luding resident rights and mous staff member N's d they were trained on all opics on 12/6/23, including buse prohibition.  Vider's November 2019 of description revealed:	F 58	3	
F 600 SS=J	Compliance and Ethic employee, contractor training to include the [Health Insurance Po Act] policy, and other policiese. Privacy Officer: Comaintenance of, and policies and procedurand handling of prote (PHI) in compliance vergulation."  Free from Abuse and CFR(s): 483.12(a)(1)  §483.12 Freedom fro Exploitation The resident has the neglect, misappropria	cs Program. Coordinate and volunteer compliance Code of Conduct, HIPAA rtability and Accountability mandatory compliance eversee the implementation, adherence to privacy es regarding the safe use cted health information with federal and state HIPAA	F 60	<sup>0</sup> See next page	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE : COMPI	
		435086	B. WING		01/0	08/2025
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 017	00/2020
DIVEDVIE	WILLEAL THO A DE CENTE	·D		611 EAST 2ND AVE		
RIVERVIE	W HEALTHCARE CENTE	:R		FLANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	any physical or chemitreat the resident's more state of the resident of the r	ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.  y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced tota Department of Health intake review, interview, depolicy review, the provider of seven sampled residents' there from physical, mental, the provider of seven sampled residents' there from physical, mental, the provider of seven sampled residents' there from physical, mental, the provider of seven sampled residents' there is the provider of seven sampled residents' there is the provider of seven sampled residents' the provider of seven sampled residents' the provider of seven sampled residents' the provider of seven s	F 60	,	dents inviron-  if ere re- wed had rule out  in the Freedom ment, In- esident e Prohi- olicy. freedom ment, In- esident buse to their  ur ran- rs (LP 2/ nonthly lave no y signs safe in uspected ally inves- iring the PI meet-	1/9/2025
	written plan for remov jeopardy via email. Th agreed-upon revision:	ne removal plan, after s, with guidance from the r for the SD DOH, was				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	. ,	E SURVEY MPLETED
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	ROVIDER OR SUPPLIER W HEALTHCARE CENTE			STREET ADDRESS, CITY, STATE, ZIP 611 EAST 2ND AVE FLANDREAU, SD 57028	•	1/08/2025
(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 C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 600	"F600. The provider I regarding the care an providing to residents p.m. The provider fail from potential further investigation by allow an overnight shift from around 7:30 a.m. on get more information understand the exten provider failed to reponecessary entities. The investigation into the assessing the resident nothing was document. The CNA has been spending investigation was submitted on 1/6 skin assessment comwith a BIMS [Brief Intrabove an eight have any potential for abust resident with a concert this morning, resident the responsible party no concerns and five	earned about concerns and services a CNA was son 1/1/25 at around 1:30 led to protect the residents abuse during the ring the CNA to keep working in 10:30 p.m. on 1/1/25 to 1/2/25. The provider failed to from the reporting party to to five situation. The port the incidents to the incidents to the incidents including into involved for injuries but inted.  Suspended as of 1/6/2025 in the initial report to DOH injuries had a inpleted and any residents had a inpleted and any residents erview for Mental Status] been interviewed regarding se by 11 am. A total of 49 is interviewed with no concerns, 1 in that was reported to DOH its with a BIMS below eight, was contacted, seven with were left a voicemail. The		DEFICIENT SOOO	NCY)	
	Abuse education provand DON B] as well a in place to monitor skinjury. Several staff frevening shift 2, night days and one from evening shift 2 in the staff of t	w with re-enactment on 1/7/2025 by [ED A]. wided by [DDCO C] to [ED A as validating documentation kin or affected body parts for rom nursing, day shift 4, shift 1; dietary, one from				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		435086	B. WING _			C 01/08/2025
	ROVIDER OR SUPPLIER W HEALTHCARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	•	5 17 00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	another staff member in any way on 1/7/20  Primary witness state who witnessed the arresident in the shin to with a different reside perpetrator put a way mouth to quiet the rehave dementia. State that this has been arralleged perpetrator in	arding if they have ever seen r abuse or neglect a resident 25, no concerns noted.  ements from other CNAs lleged perpetrator kick a wice, and a separate incident ent where the alleged sholoth over a resident's sident. Both those residents ements from staff indicate a ongoing issue and the mproves their actions for a	F 6	00		
	but then slips back ir serious concern that potentially re-offend. The CNA's making the interviewed and a re- been conducted by [ suspended 1/6/2025	g talked to by administration, not their old ways. There is the alleged perpetrator will ne allegation have been enactment of events has ED A]. The perpetrator was pending investigation.  [question] were assessed for				
	harm due to cognitio on alert charting for The [perpetrator] had completed on 10/11/abuse.  The provider needs to the completed on 10/11/abuse.	e to assess for psychosocial n status. Both were placed 72 hours.  d a background check 2023 with negative results for o take immediate action to stall abuse from occurring.				
	The provider failed to required entities, allo to work a shift follow abuse, failed to cond	o report the incidents to the wed the alleged perpetrator ing the report of alleged uct a thorough investigation, neir abuse/neglect policy.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		435086	B. WING _			C <b>01/08/2025</b>
	ROVIDER OR SUPPLIER W HEALTHCARE CENT	ER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	Continued From pag	e 11	F 6	00		
	educated [ED A and abuse reporting, sus investigation and inv phone.	ted 1/6/2025. [DDCO C], DON B] on abuse policy, pension pending estigation by 1/6/2025 via				
	policy on 1/7/2025 ar	nd prior next working shift.				
	Grievances for [the last] 30 days were reviewed for possible abuse allegations on 1/7/2025.  [Nurse's] notes for residents were reviewed for the last 30 days for possible abuse allegations on 1/7/2025.					
	1/07/25 and the Med	ity assurance and ement] is being completed ical Director was informed of practice and current plan.				
		n., the survey team ediacy was removed. After diacy, the severity and scope				
	The census was 62.					
	dated 12/31/24 revea *The SD DOH receiv detailing allegations wanted to remain an *The complainant cla J to management pro	ed an email on 12/27/24 of abuse by CNA J. They onymous. aimed to have reported CNA				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		435086	B. WING			C 01/08/2025	
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028		611 EAST 2ND AVE		00/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE
F 600	would be good only for continued her verbal.  *The complainant desinvolving resident 7 adid not mention a datResident 7 was non-The complainant and resident 7 using a fullCNA J "slammed a complainant felt means to quiet the re.  *The complainant felt means to quiet the re.  *The complainant desincident involving resident 9 had demout to people walkingResident 9 was sittin hallway next to anonyResident 9 reached was walking past and quick."  -CNA J was witnesse twice in the shin.  3. Review of an addit intake form dated 1/6  *The SD DOH received different anonymous self-transparent and she is abusing re.  *"There is a CNA that and she is abusing re.  *"I have witnessed he [them] names, which.  *"I have reported this avail."	g talked to before, she or a week if that before she and physical abuse." scribed a witnessed incident and CNA J. The complainant e. verbal. d CNA J were transferring body mechanical lift. doth over [resident 7's] ere with her fingertips. as if CNA J did that as a sident. scribed another witnessed ident 9 and CNA J. The mention a date. entia and tended to reach by to hold their hand. ag in her wheelchair in the rous staff member N. out towards CNA J as she I said, "Hey come here d to have kicked resident 9  dional SD DOH complaint //25 revealed: ed an email on 1/3/25 from a complainant. works here named [CNA J] is idents." er kicking, yelling and calling is mental abuse." to the administration to no	F	600			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		435086	B. WING				08/ <b>2025</b>
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028			00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	at 4:15 p.m. and requincluding staff schedules revealed the work an overnight ship of the schedules revealed:  *She denied that any allegations of abuse of staff.  *When questioned specifications are sident's mouth, she such incidents.  *Refer to F600 finding confirmed she was as as as a staff.  *Uning one incident, was assisting CNA Jusing the full body medicated the cloth of about a minute.  -Anonymous staff medicated the cloth of about a minute.  -Anonymous staff medicated the cloth of about a minute.  -Anonymous staff medicated the cloth of about a minute.  -I brought [resident start of the cloth of a start of the cloth o	ntered the facility on 1/6/25 lested several items, ales. Review of the staff hat CNA J was scheduled to ft that night.  That 5:28 p.m. with DON B staff had reported for neglect against any other recifically about any ts involving a staff member olding a cloth over a denied any knowledge of as 8 and 9 where DON B ware of the incidents.  The word of the incidents.  The word of the incidents of the incidents of the incidents of the incidents.  The word of the incidents of the inc	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		435086	B. WING		C 01/08/2025	
	ROVIDER OR SUPPLIER W HEALTHCARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	1 01/00/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 600	when the kicking inc was within the last the *They explained the report those incident previously when incidents would improve would return to the at *Anonymous staff mand another staff maincidents to ED A.  -Anonymous staff me incidents to ED A and DON B ab revealed:  *On 1/2/25, DON B incidents incident	ember M could not recall ident occurred, but guessed it bree to four weeks. reason why they did not as immediately was because dents were reported, CNA J's we for a short while, but then abusive behaviors. ember M confirmed that they ember reported the above	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		435086	B. WING			01/	08/2025
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER		6	TREET ADDRESS, CITY, STATE, ZIP CODE  11 EAST 2ND AVE  LANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	others."  -CNA J had denied hat *DON B indicated she (residents 2, 8, and 1 concerns regarding a residents she talked the she did not document part of the investigation *They confirmed there documented disciplinated during her employme she conducted a visuand 9 on 1/2/25 prior about the allegations. *Resident 9 was not a remembered the incident *Resident 9 was still it looked at her legs and -The resident did not *DON B confirmed she resident 7 "as much."  -"I laid eyes on her. [Find the talked to. I did not did an up-close assess her."  -She confirmed the assess her."  -She confirmed the assess her."  -She did not notice ar trauma around the resident she confirmed she covers, but the room able to visualize resident area.  -She did not notice ar trauma around the resident she visual inspections.	arming any residents. e interviewed other residents 0) to see if they had any buse or neglect. None of the to expressed concerns. In any of those interviews as on. It any of those interviews as on. It any actions against CNA J Int with the provider. It at 7:04 p.m. with DON B  ual inspection of residents 7 to speaking with CNA J  able to verbalize if she dent or not. In her nightgown, so DON B d did not see any bruising. act any differently. It is a	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25.	_	<del></del>		
		435086	B. WING				08/2025
NAME OF PR	ROVIDER OR SUPPLIER		Į.	S	TREET ADDRESS, CITY, STATE, ZIP CODE	017	00/2020
			611 EAST 2ND AVE		11 EAST 2ND AVE		
RIVERVIE	W HEALTHCARE CENTE	ER .		F	LANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
F 600	more private like risk provider's system of e incidents).  *She confirmed she le on 1/1/25 around 1:30 nurse (RN) F contacted -RN F told her that state concerns.  -RN F did not provide concerns, and DON E questions about the concerns, and DON E and I the morning of 1/2 hours	cal chart versus "something management" (the electronically tracking earned about the allegations 0 p.m. when registered ed her about the allegations. aff had come forward with any details about the 3 did not ask further concerns. ED A about the allegations /2/25. at CNA J worked from 10:30 0 a.m. on 1/2/25 after she ions against the CNA. in at 12:08 p.m. on 1/3/25 and 2:00 p.m. uspended any staff pending re. have a conversation with that was the steps I needed	F	600	DEFICIENCY)		
	-She indicated she hat training when she too -She was not aware t	oordinator prior to that. ad not received a lot of ok over the DON position. hat the above allegations					
	of South Dakota deta were required to have *She was not aware of neglect prohibition po	of the provider's abuse and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		435086	B. WING			C 01/08/2025	
	ROVIDER OR SUPPLIER W HEALTHCARE CENTI	ER	•	6	STREET ADDRESS, CITY, STATE, ZIP CODE S11 EAST 2ND AVE FLANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	and was allowed to we to the investigation.  -The allegations of all the required entities.  -The investigation was allowed to we allow the pause and neglect programmer and programmer an	d the following: ended pending investigation work an overnight shift prior  buse were not reported to as not documented.  25 at 2:21 p.m. with DDCO C  suspension related to his rovider's policy regarding evention and prohibition. behave been acting as the nator.  25 at 9:53 a.m. with DON B ed: led her on 1/1/25, DON B ent of the details of the ne allegations that CNA J to resident 7's mouth and the shin. Evever, of the allegations of tootentially rough when dents. that, to her understanding, happened several weeks the came to ED A recently to  on that staff should have the abuse. on that all allegations should ously, and the allegations vestigated thoroughly. Investigation should have ause analysis, the "5 Why's"	F	600			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		435086	B. WING				08/2025
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DI)/ED)//E)		-		6	11 EAST 2ND AVE		
RIVERVIEV	N HEALTHCARE CENTE	:R		F	LANDREAU, SD 57028		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
	happened two to three not remember exactly *Resident 9 was sittin hallway outside her ro *Resident 9 tended to people to grab them. *Anonymous staff me reaching towards CNA-CNA J kicked resider "hard enough that [resitbut not hard enough that [resitbut not hard enough that greatly very verbal, so resabout that incident. *Anonymous staff me J say to resident 9, "Y tell you've had a hard smoked all your life." *Anonymous staff me away from the situation was okay. *That event potentially of December 2024, but N was not sure. *Anonymous staff me incident to the nurse of timeAnonymous staff me were required to repoimmediatelyAnonymous staff me from CNA J.	view on 1/8/25 with wher N revealed: g CNA J and resident 9 e weeks ago, but they could when that occurred. g in her wheelchair in the boom. o reach her hand out to  mber N observed resident 9 A J. ot 9 twice on the right shin sident 9] made a face about	F	600			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		435086	B. WING				C 08/2025
	ROVIDER OR SUPPLIER W HEALTHCARE CENTI	ER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 600	specific when detailir and provided the specific with expectation of the specific with detailir and provided the specific with a specific with detailir when reporting their with the specific with detail when reporting their with the specific with detail when reporting their with the specific with detail when reporting their with the specific with the s	aff members M and N were ng the alleged abuse to ED A reific incidents. In reported the alleged abuse rovements were observed in vards residents. In the alleged abuse concerns to RN F.  25 at 12:09 p.m. with RN F  Two staff members reported se on 1/1/25. If were specific about the If exactly what happened that If he concerns. In the concerns. In the concerns In the EMR that indicated she after the alleged abuse was In the concerns to RN F. In the EMR that indicated she after the alleged abuse was In the concerns to RN F. In the EMR that indicated she after the alleged abuse was In the EMR that indicated she If the concerns to RN F. In the EMR that indicated she after the alleged abuse was In the EMR that indicated she after the indicated she If the concerns to RN F. In the EMR that indicated she after the alleged abuse was In the EMR that indicated she after the indicated she If the concerns to RN F.  In the EMR that indicated she If the concerns to RN F.  In the EMR that indicated she If the concerns to RN F.  If the	F	600			

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3	) DATE SURVEY COMPLETED
	435086	B. WING			C <b>01/08/2025</b>
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	ı	01/06/2025
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	HOULD BE	(X5) COMPLETION DATE
mobility, and eating -She required the u  15. Review of reside *She was admitted *Her diagnoses inclunspecified muscule depression, demendelsewhere, and sender *Her care plan indiction for locomotion, requassistance with battle and grooming.  *There was nothing had been assessed reported.  *Her BIMS assessnown 10/16/24 significant which indicated she impaired.  16. Review of CNA *Her hire date was *She was trained or topics on 10/2/23, in abuse prohibition.  *The background of did not reveal any canother individual.  *A "Disciplinary Action B on 1/2/25 include -"[DON B] had convolution complaints of aggree with residents. [DOI though we have backgreed that attituted the state of the st	see of a stand-lift for transfers.  ent 9's EMR revealed: on 6/24/24. uded repeated falls, ar degeneration, unspecified tia in other diseases classified ille degeneration of brain. eated she used a wheelchair uired "maximal/substantial" ning, dressing, bed mobility,  in her EMR that indicated she after the alleged abuse was  nent score was 3 on the change MDS assessment, was severely cognitively  J's employee file revealed: 10/1/23. In all the required training including resident rights and  neck completed on 10/11/23 irriminal charges of abuse of on Form" completed by DON d the following: rersation with [CNA J] about ressive cares [and] comments N B] explained that even d days, we need to keep ude at home [and] not to	F 60	0		
	ROVIDER OR SUPPLIER  W HEALTHCARE CEN  SUMMARY: (EACH DEFICIEN REGULATORY OF  Continued From par mobility, and eating -She required the u  15. Review of reside *She was admitted *Her diagnoses inclunspecified muscula depression, dement elsewhere, and sen *Her care plan indic for locomotion, requassistance with batt and grooming. *There was nothing had been assessed reported. *Her BIMS assessn 10/16/24 significant which indicated she impaired.  16. Review of CNA *Her hire date was *She was trained or topics on 10/2/23, in abuse prohibition. *The background of did not reveal any canother individual. *A "Disciplinary Acti B on 1/2/25 include -"[DON B] had convection complaints of aggre with residents. [DOI though we have bac [redacted] that attitut project on others. [I	A35086  ROVIDER OR SUPPLIER  WHEALTHCARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20 mobility, and eatingShe required the use of a stand-lift for transfers.  15. Review of resident 9's EMR revealed: *She was admitted on 6/24/24. *Her diagnoses included repeated falls, unspecified muscular degeneration, unspecified depression, dementia in other diseases classified elsewhere, and senile degeneration of brain. *Her care plan indicated she used a wheelchair for locomotion, required "maximal/substantial" assistance with bathing, dressing, bed mobility, and grooming. *There was nothing in her EMR that indicated she had been assessed after the alleged abuse was reported. *Her BIMS assessment score was 3 on the 10/16/24 significant change MDS assessment, which indicated she was severely cognitively impaired.  16. Review of CNA J's employee file revealed: *Her hire date was 10/1/23. *She was trained on all the required training topics on 10/2/23, including resident rights and abuse prohibition. *The background check completed on 10/11/23 did not reveal any criminal charges of abuse of	A BUILDING  435086  ROVIDER OR SUPPLIER  WHEALTHCARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20  mobility, and eatingShe required the use of a stand-lift for transfers.  15. 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Review of CNA J's employee file revealed: *Her hire date was 10/1/23. *She was trained on all the required training topics on 10/2/23, including resident rights and abuse prohibition. *The background check completed on 10/11/23 did not reveal any criminal charges of abuse of another individual. *A "Disciplinary Action Form" completed by DON B on 1/2/25 included the following: -"IDON B] had conversation with [CNA J] about complaints of aggressive cares [and] comments with residents. [DON B] explained that even though we have bad days, we need to keep [redacted] that attitude at home [and] not to project on others. [DON B] explained to [CNA J]	ROVIDER OR SUPPLIER  WHEALTHCARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20 mobility, and eatingShe required the use of a stand-lift for transfers.  15. Review of resident 9's EMR revealed: *She was admitted on 6/24/24. *Her diagnoses included repeated falls, unspecified depression, dementia in other diseases classified elsewhere, and senile degeneration, unspecified depression, dementia in other diseases reported. *Her BIMS assessment score was 3 on the 10/16/24 significant change MDS assessment, which indicated she was severely cognitively impaired.  16. Review of CNA_J's employee file revealed: *Her hire date was 10/1/23. *She was atrained on all the required training topics on 10/22/3, including resident rights and abuse prohibition. *The background check completed by DON B on 11/2/5 included the following: -"[DON B] had conversation with [CNA_J] about complaints of aggressive cares [and] comments with residents. [DON B] explained that even though we have bad days, we need to keep [redacted] that attitude at home [and] not to project on others. [DON B] explained to [CNA_J]	A BUILDING  A STREET ADDRESS, CITY, STATE, ZIP CODE  STREAT 2ND AVE FLANDREAU, SD 57028  SUMMARY STATEMENT OF DEFICIENCES  SUMMARY STATEMENT OF DEFICIENCES  (EACH DEPREMEND MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)  Continued From page 20  mobility, and eatingShe required the use of a stand-lift for transfers.  15. Review of resident 0's EMR revealed:  "She was admitted on 6/24/24.  "Her diagnoses included repeated falls, unspecified depression, dementia in other diseases classified elsewhere, and senile depeneration nuspecified depression, dementia in other diseases classified elsewhere, and senile depeneration of brain.  "Her care plan indicated she used a wheelchair for locomotion, required "maximal/substantia" assistance with bathing, dressing, bed mobility, and grooming.  "There was nothing in her EMR that indicated she had been assessed after the alleged abuse was reported.  "Her BIMS assessment score was 3 on the 10/16/24 significant change MDS assessment, which indicated she was severely cognitively impaired.  16. Review of CNA J's employee file revealed:  "Her hire date was 10/1/23.  "She was trained on all the required training topics on 10/2/23, including resident rights and abuse prohibition.  "The background check completed on 10/11/23 did not reveal any criminal charges of abuse of another individual.  "A "Disciplinary Action Form" completed by DON B on 12/25 included the following:  "IDON B] had conversation with [CNA J] about complaints of aggressive cares [and] comments with residents. [DON B] explained that even though we have bad days, we need to keep [redacted] that attitude at home [and] not to project on others. [DON B] explained to [CNA J]

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		435086	B. WING			C <b>01/08/2025</b>	
	ROVIDER OR SUPPLIER W HEALTHCARE CENTI	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 600	suspension procedur  17. Review of the prodescription revealed perform duties in confederal regulations."  18. Review of the proof Nursing Services (revealed:  *"Job summary: Is director (Eoperations, activities, care staff, as governed and state and federal the nursing department maintain high standar knowledgeable of indicand by implementing practices."  *"Essential Functions -1. Develops and material philosophy, objective policy and process material for assigned under monitoring and follows."  -2. Manages, supervitaction for assigned under monitoring and follows3. Establishes system objectives and goals, planning period main documentation reflections.  6. Demonstrates as knowledge of certifications.  8. Validates that research as the survey requirements, 8. Validates that research as the sur	ten warning, probation, e will be followed."  Povider's March 2012 CNA job "the CNA is expected to appliance with state and  Povider's March 2012 Director DNS) job description  Prectly accountable to the state and success of the resident ed by the Center policies, and success of the resident end by the Center policies, are gulations. Validates that ent continues to develop and and of excellence by being sustry changes and trends, up-to-date nursing  State of the day-to-day and success of the resident end of excellence by being sustry changes and trends, up-to-date nursing  State of the day-to-day and success of the resident end of excellence by being sustry changes and trends, up-to-date nursing  State of the day-to-day and service and develops plans of an unit of the provider of the pro	F	600			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		435086	B. WING		C 01/08/2025		
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	1 01100/2023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 600	regarding resident of staffing problems, a 13. Understands and federal regulate maintain positive re	ten communication with ED care activities, personnel or and other related topics. In the relationships with state bry agencies, and works to lationships."	F 60	00			
	Executive Director j *"Job summary: The directly accountable leadership and man center. Manages de health services and responsive to custo *"Essential Functior2. Quality Managera. Lead the process programs to mainta established goalsb. Responsible to clean, and well-orgatigh standard of card. Verify the Ce	ns gement ss to develop and implement in quality of care to meet maintain a safe, healthy, anized building that reflects a					
	licensure3. Human Resource. Ultimately ac staffing of the Centef. Hire and manag laws, and Center pog. Facilitate comm administrative level promote optimum p understanding of goj. Implement a r embodies the comp	e Management countable for the adequate er. e within Federal and State blicies and processes. unications from to staff and vice versa to erformance and bals. unanagement style that any's core mission, values, ds department managers to					

* /		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		435086	B. WING	B. WING		C 1/08/2025	
	ROVIDER OR SUPPLIER W HEALTHCARE CENTI	ER		STREET ADDRESS, CITY, STATE, ZIP CO 611 EAST 2ND AVE FLANDREAU, SD 57028		11700/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	grievances through to any necessary invest federal and state reg policies as they apply -c. Abuse Coordinate implementation of ponecessary to prohibit neglect, including but training, prevention, ireporting/response. Oneglect investigations -d. Compliance Liais Compliance and Ethiemployee, contractor training to include the [Health Insurance Poact] policy, and other policies."  *"Knowledge, Skills, -1. Familiarity with Stregulations, and appliaws."  20. Review of the proaction	agement cial: Responsible for ance process. de: receiving and tracking to their conclusion, leading cigations, and complying with ulations and company to the grievance process. or: Oversee the licies and procedures and prevent abuse and to not limited to: screening, dentification, protection, and coordinate abuse and s. con: Oversee the facility cs Program. Coordinate to, and volunteer compliance to Code of Conduct, HIPAA ortability and Accountability to mandatory compliance and Abilities that Nursing Center rules and dicable Federal and State  avider's November 2019 exploitation policy revealed: by superior and are reported to the resident and/or Regional mediately." to defined as an act by an es, exploits, or jeopardizes to welfare, or safety,	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		435086	B. WING	B WING		C 01/08/2025	
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE			6	STREET ADDRESS, CITY, STATE, ZIP CODE 11 EAST 2ND AVE FLANDREAU, SD 57028	1 017	00/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 600	harassment."  *"3. Abuse, neglect, oOne or more reside  *"4. If abuse, neglect, is suspected, act immresident from addition  *"5. Act quickly to gat an employee is suspend an investigation, for the well as the protection  -A staff person suspeneglect, or exploitation any resident until the takes action to assure  *"6. Complete an Incitation appropriate document Service Notes."  *"7. Initiate an investigation to leaving their resident until the alleged abustion to leaving their resident of the suspected or alternation in the suspected	or exploitation can involve: int(s) and staff." or exploitation of a resident inediately to protect the inal harm." her pertinent information. If ected of the abuse, the ed pending the outcome of the employee's protection as of the resident. cted or accused of abuse, in does not have access to Community investigates and the resident safety." dent Report and make tation in the resident's  gation. Staff on duty at the the occurred are interviewed espective shift. This applies the residents in the area." propriate State agency as ing the required reporting  int's family/significant other(s) lileged abuse." The type of incident, it may to call the Long-Term Care the type of incident, it may to call the Long-Term Care the type of incident, it may to call the Long-Term Care the type of incident, it may to call the Long-Term Care the type of incident, it may to call the Long-Term Care the type of incident, it may to call the Long-Term Care the type of incident, it may to call the Long-Term Care the type of incident, it may to call the Long-Term Care the type of incident the appropriate the type of incident the appropriate the cated/alleged abuse, the type of incident the appropriate the cated and the appropriate t	F	600			

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		435086	B. WING			C
	ROVIDER OR SUPPLIER W HEALTHCARE CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	1 0	1/08/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 600	against for making a protection from retali Community from taki action related to false or performance defice.  21. Review of the proferedom from Abuse Punishment, Involund Misappropriation of Exploitation policy re *"Policy Statement: 6 be free from abuse, i physical abuse  -The Center implements of the tresidents are staff"  *Definitions:  -"Abuse: The willful in resulting physical har 'Willful,' as used in the individual acted of individual must have harm."  -"Mental Abuse: The conduct which cause cause the resident to intimidation, fear, shadegradation. It includes the individual must have harms."  -"Verbal Abuse: May of mental abuse. Ver of oral, written, or ge sounds, to residents regardless of age, at disability.	e, he/she is not retaliated good faith report. However, ation does not prevent the ng appropriate personnel e reporting, policy violations, iencies."  Divider's October 2022  E, Neglect, Corporal tary Seclusion, Mistreatment, Resident Property, and vealed: Each resident has the right to including verbal, mental,or  Ents policies and processes not subjected to abuse by  infliction of injurywith rm, pain, or mental anguish. is definition of abuse, means deliberately, not that the intended to inflict injury or use of verbal or nonverbal is or has the potential to experience humiliation, ame, agitation, or les but is not limited to it verbal assault that includes	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	40000	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>  U1/</u>	08/2025	
RIVERVIE	W HEALTHCARE CENTE	ER			11 EAST 2ND AVE LANDREAU, SD 57028			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE	
F 600	mocking, insulting, rid -"Physical Abuse: Inc hitting, slapping, pund biting, kicking throwing shoving. Physical abuor correcting behavior punishment." -"Corporal Punishment injury upon a resident is used as a means to Includes but is not lim slapping of hands, flic object." -"Mistreatment: Inappexploitation of a resid -"Mandatory Reporter employee, manager, contractor of a Medic nursing facility" -"Staff: Staff includes director, consultants, Staff also includes ca and services on behards absence of a shorter requirement, but not la allegations is made, if allegation involve abuinjury or not later than cause the allegation on tresult in serious be clock time)" -"Serious Bodily Injury extreme physical pair -"Staff to Resident Abdirected by staff to a started and the staff to a staff to Resident Abdirected by staff to a st	Harassing a resident; diculing" ludes, but is not limited to, ching, choking, pinching, g objects, grabbing, and use also includes controlling r through corporal  Int: Inflicting physical pain or t. Physical punishment that to correct or control behavior. Inited to, pinching, spanking, cking, or hitting with an  Propriate treatment or ent." The Anyone who is an agent, operator, owner, or are or Medicaid certified  employees, medical contractors and volunteers. Tregivers who provide care all of the Center" Is as soon as possible, in the State time frame ater than 2 hours after the f the events that cause the use or result in serious bodily in 24 hours if the events that do not involve abuse and do rodily injury. (Based on real  The Means an injury involving The Indian Control of the control The Indian Control Th	F	600				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		435086	B. WING		C 01/08/2025		
	ROVIDER OR SUPPLIER W HEALTHCARE CENT	1		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	1 01/00/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION		
F 600	types of abuse, negler resident property, an -"4. Identification: The procedures to assist neglect, and exploitation: The thorough investigation and/or allegations of exploitation of resider resident property, ming unknown source, in a federal regulations."  -"6. Protection: The Comply from physical and post after an investigation of resider an investigation."  -"7. Reporting and Rimmediately reports allegations of abuse, residents,mistreation unknown source in a federal law."  22. Review of the property of the property of the property of the property, identify, investigation of resident property, and the property of the prope	res to prevent and prohibit all ect, misappropriation of d exploitation." e Center implements written staff in identifying abuse, tion of residents" e Center conducts a of potential, suspected abuse, neglect, and onts, misappropriation of streatment, and injuries of accordance with state and center protects residents ychosocial harm during and ." esponse: The Center all suspected and/or neglect, and exploitation of timent, and injuries of accordance with state and covider's November 2016 of tification policy revealed: The Center complies with quirements to screen, train, estigate, protect, and report reatment, exploitation, and esident property." ons involving mistreatment, cluding injuries of unknown and misappropriation of the reported immediately to the ED) and to other officials in teral and State law. eged violation, an	F 60				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		435086	B. WING		C 01/08/2025
	ROVIDER OR SUPPLIER W HEALTHCARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	, 000.2020
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 600	Continued From page	tion.	F 60		
	ED or his/her design other officials in acc State law, not to exc incident." *"5. Instances of dis policies and process action up to and inc	stigations are reported to the nated representative and to cordance with Federal and ceed five working days of the cregard for the Center's ses is cause for corrective luding suspension, corting to licensing agencies."			
	Investigation policy *"Policy Statement: thorough investigati and/or allegations o exploitation of reside resident property, m unknown origin, in a federal regulations." *"1. The Executive I abuse coordinator a assigning and overs with investigations." *"2. The Center ider persons, including ti perpetrator, witness have knowledge of i *"3. The Center prof and after the course *"4. Through investi determine if the abu misappropriation of has occurred and to cause. *"5. The Center mai documentation of the	The Center conducts a on of potential, suspected f abuse, neglect, and ents, misappropriation of nistreatment, and injuries of accordance with state and Director is the designated and is responsible for seeing staff that are to assist on tifies and interviews involved the alleged victim, alleged the allegations."  Itects the alleged victim during the investigation."  Itegation, the Center works to use, neglect, exploitation, property, and/or mistreatment of determine the extent and			

` ,		IDENTIFICATION NI IMPED:		MULTIPLE CONSTRUCTION  JILDING		(X3) DATE SURVEY COMPLETED	
		435086	B. WING		C 01/08/2025		
NAME OF PRO	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	06/2025	
RIVERVIEW	HEALTHCARE CENTE	R		i11 EAST 2ND AVE FLANDREAU, SD 57028			
(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 609 SS=J	property, exploitation, of unknown source, ic conducted by the QAA Assurance] Committee reporting, or policy/proconducted as approproconducted as a serious to the allegate that cause and do not resist the administrator of the officials (including to the administrator of	propriation of resident mistreatment, and injuries lentified through analysis A [Quality Assessment and e, with intervention, ocess modification riate."  //iolations i)(A)(B)(c)(1)(4)  se to allegations of abuse, or mistreatment, the facility  that all alleged violations ect, exploitation or region of resident property, tely, but not later than 2 cion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve cult in serious bodily injury, to be facility and to other the State Survey Agency and ses where state law provides ever care facilities) in the law through established	F 600	1.For residents 7 and 9 appropriate staff men were put on administrative leave. Resid were interviewed and felt safe in their er ment or didn't recall.	abuse olved. a physiabuse. es and part of  the reedom ent, Insident e Prohibicy. The ne reedom ent, Insident buse to their erectors their erectors of their erectors of ein spected y invesing the I meet-	1/9/2025	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3)	(X3) DATE SURVEY COMPLETED	
		435086	B. WING_			C
	ROVIDER OR SUPPLIER W HEALTHCARE CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	<u> </u>	01/08/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	by: Based on South Da (SD DOH) complaint document review, ar failed to notify the re of physical, mental, a nursing assistant (CI sampled residents (T Findings include:  1. IMMEDIATE JEOI Notice of immediate verbally and in writin p.m. to director of nu director of clinical op to failure to report all removal of the imme  On 1/8/25 at 4:30 p.m. written plan for the re jeopardy. The remova after 4:30 p.m. on 1/ the removal plan for p.m. included action allegations of abuse  "F609. The provider regarding the care a providing to resident p.m. The provider fa from potential furthe investigation by allow an overnight shift fro around 7:30 a.m. on get more information understand the exter provider failed to rep	kota Department of Health tintake review, interview, and policy review, the provider quired entities of allegations and verbal abuse by certified NA) J towards two of seven 7 and 9).  PARDY NOTICE jeopardy at F609 was given g via email on 1/8/25 at 3:57 ursing (DON) B and division derations (DDCO) C relating legations of abuse. A plan for diacy was requested.  m., DDCO C emailed a gemoval of the immediate val plan was approved soon 8/25. It was determined that F600 sent on 1/7/25 at 12:56 items to report the to the required entities.  learned about concerns and services a CNA was so on 1/1/25 at around 1:30 illed to protect the residents	F 6	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED	
		435086	B. WING			C 01/08/2025	
	ROVIDER OR SUPPLIER W HEALTHCARE CENTI			STREET ADDRESS, CITY, STATE, ZIP COI 611 EAST 2ND AVE FLANDREAU, SD 57028		71/06/2025	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 609	nothing was documed. The CNA has been spending investigation was submitted on 1/6 skin assessment committed any potential for abust residents were interviously resident with a concert this morning, resident the responsible party no concerns and five reporting party has his investigation/interview completed by 10 am Abuse education provand DON B] as well as in place to monitor skinjury. Several staff frevening shift 2, night days and one from exactivities, therapy and been interviewed reganother staff member in any way on 1/7/20.  Primary witness state who witnessed the all resident in the shin twith a different reside perpetrator put a was mouth to quiet the resident in the shin to with a quiet the resident in the shin to with a quiet the resident in the shin to with a different reside perpetrator put a was mouth to quiet the resident in the shin to with a different reside perpetrator put a was mouth to quiet the resident in the shin to with a different reside perpetrator put a was mouth to quiet the resident in the shin to with a different reside perpetrator put a was mouth to quiet the resident in the shin to with a different reside perpetrator put a was mouth to quiet the resident in the shin to with a different resident in the shin to with a d	allegations including nts involved for injuries but inted.  uspended as of 1/6/2025 a. The initial report to DOH 6/2025. All residents had a inpleted and any residents terview for Mental Status] been interviewed regarding se by 11 am. A total of 49 iewed with no concerns, 1 am that was reported to DOH its with a BIMS below eight, awas contacted, seven with were left a voicemail. The aid a thorough as with re-enactment on 1/7/2025 by [ED A]. wided by [DDCO C] to [ED A is validating documentation in or affected body parts for from nursing, day shift 4, shift 1; dietary, one from vening; maintenance, if they have ever seen ar abuse or neglect a resident 25, no concerns noted.	F 6	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		435086	B. WING		01/08/2025	
	ROVIDER OR SUPPLIER W HEALTHCARE CENTI	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028		
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F 609	but then slips back in serious concern that potentially re-offend.  The CNA's making the interviewed and a rebeen conducted by [I suspended 1/6/2025]  The two residents in physical harm, unable harm due to cognition on alert charting for 7.  The [perpetrator] had completed on 10/11/2 abuse.  The provider needs to prevent further potenth further potenth for a shift following abuse, failed to conducted [ED A and a failed to follow the complete on 10/11/2 abuse.  The event was reported and failed to follow the conducted [ED A and a failed	g talked to by administration, to their old ways. There is the alleged perpetrator will a legation have been enactment of events has ED A]. The perpetrator was pending investigation.  [question] were assessed for e to assess for psychosocial in status. Both were placed 22 hours.  If a background check 2023 with negative results for the incidents to the wed the alleged perpetrator ing the report of alleged uct a thorough investigation, weir abuse/neglect policy.  Ited 1/6/2025. [DDCO C], DON B] on abuse policy, bension pending estigation by 1/6/2025 via cated on the facility abuse and prior next working shift.	F 60			
	tor possible abuse al	legations on 1/7/2025.				

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F 609	the last 30 days for p 1/7/2025.  An Ad hoc [meaning needed"] QAPI [qual performance improve 1/07/25 and the Med the alleged deficient Called at 10 AM by [ The immediacy at F6 been removed on 1/2 review. After removal severity and scope w  The census was 62.  2. Review of the SD dated 12/31/24 reveal *The SD DOH receive detailing allegations wanted to remain an *The complainant cla concerns to manage not include any dates were reported"I reported [CNA J's prior, she would get hours cut but within a rude and rough with *See F600 finding 2 alleged abuse.  3. Review of an addi intake form dated 1/6 *The SD DOH receive different anonymous	"when necessary or ity assurance and ement] is being completed lical Director was informed of practice and current plan. DON B]."  509 was determined to have 7/25 at 4:30 p.m. after onsite of the immediacy, the vas a level G.  DOH complaint intake form aled:  Yed an email on 12/27/24 of abuse by CNA J. They onymous.  Aimed to have reported their ment previously. They did is about when the concerns  I rudeness and 'roughness' talked [to] and [had her work] a week [she's] back to being the residents."  For details pertaining to the sided an email on 1/3/25 from a	F 60	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W HEALTHCARE CENTE			6	STREET ADDRESS, CITY, STATE, ZIP CODE S11 EAST 2ND AVE FLANDREAU, SD 57028	1 017	00/2023
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F 609	not include any dates were reported.  -"I have reported this avail."  *See F600 finding 3 falleged abuse.  4. Interview on 1/6/25 revealed:  *She denied that any allegations of abuse of staff.  *When questioned spknowledge of incident kicking residents or hresident's mouth, she such incidents.  5. Confidential intervianonymous staff ments anonymous staff ments are to come forward with J, due to CNA J's retatation and another staff ments anonymous staff ments and another staff ments and ano	nent previously. They did about when the concerns to the administration to no or details pertaining to the staff had reported or neglect against any other recifically about any ts involving a staff member olding a cloth over a denied any knowledge of ew on 1/6/25 with other M revealed: when M was initially afraid the allegations against CNA aliatory nature. In the most of the	F	609			

I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED		
		435086	B. WING			C <b>01/08/2025</b>		
	ROVIDER OR SUPPLIER W HEALTHCARE CEN	ΓER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028		01700/2023		
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F 609	Continued From page	ge 35	F 60	9				
	revealed:  *He denied that any of abuse or neglect *However, when as CNA J allegedly have having held a cloth the confirmed he had allegations.  -He explained that the forward those allegations done.  *He confirmed the atto the required entity.  7. Continued intervitient of and DON B atto the required the allegations to the reservine the allegations to the reservine the of abuse should have	ew on 1/6/25 at 6:35 p.m. with bout the allegations revealed: ey did not report those						
	revealed: *She confirmed she on 1/1/25 around 1: nurse (RN) F contac -RN F told her that s	25 at 7:04 p.m. with DON B  learned about the allegations 30 p.m. when registered cted her. staff had come forward with						
	concerns, and DON questions about the *She did not contac until the morning of	t ED A about the allegations						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER W HEALTHCARE CENT	ER		6	STREET ADDRESS, CITY, STATE, ZIP CODE S11 EAST 2ND AVE FLANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	learned of the allegar -CNA J did not clock 1/3/25 and worked ur *DON B explained th since July 2024. She (MDS) Assessment of -She was not aware were the type that re *She was not aware of South Dakota deta were required to hav *She was not aware neglect prohibition poinvestigating allegativ *She again confirmed were not reported to they should have been 9. Interview on 1/7/25 revealed: *ED A was placed on failure to follow the p abuse and neglect por -He was supposed to abuse/neglect coordi *She expected all allebeen taken seriously entities within the recent of the seriously and DDCO C revealed *DDCO C explained the above incidents of the seriously ago, and the witness report the incidentsIt was her expectation immediately reported	o a.m. on 1/2/25 after she tions against the CNA. back in until 12:08 p.m. on ntil around 2:00 p.m. at she had been the DON was the Minimum Data Set coordinator prior. that the above allegations quired reporting. of the Administrative Rules alling what type of incidents to been reported. of the provider's abuse and one of abuse and neglect. It allegations of abuse and neglect. It allegations of abuse the required entities when ten.  5 at 2:21 p.m. with DDCO Coordinator prior is suspension related to his provider's policy regarding revention and prohibition. To have been acting as the nator. The provider is policy regarding to have been acting as the nator. The provider is policy regarding to have been acting as the nator. The provider is policy regarding to have been acting as the nator. The provider is policy regarding to have been acting as the nator. The provider is policy regarding to have been acting as the nator. The provider is policy regarding to have been acting as the nator. The provider is policy regarding to have been acting as the nator. The provider is policy regarding to have been acting as the nator. The provider is policy regarding to have been acting as the nator. The provider is policy regarding to have been acting as the nator. The provider is policy regarding to have been acting as the nator. The provider is policy regarding to have been acting as the nator. The provider is policy regarding to have been acting as the nator is policy to have been acting as the nator. The provider is policy to have been acting as the nator is policy to have been acting as the nator. The provider is policy to have been acting as the nator is policy to have been acting as the nator.	F	609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		435086	B. WING		C 01/08/2025
	ROVIDER OR SUPPLIER W HEALTHCARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	1 01/00/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 609	should have been in  11. Refer to F600 fin regarding when the abrought their concert that ED A learned alson 12/30/24 and had the incidents.  12. Review of six emincluding CNA J, reviewed initial and/of topics of abuse and mandatory reporting  13. Review of the proof Nursing Services revealed:  *"Essential Function6. Demonstrates knowledge of certificts survey requirements8. Validates that is consistently meet stafor long-term care fa10. Maintains oper regarding resident castaffing problems, ar13. Understands and federal regulator maintain positive relations4. Review of the processing functions4. Compliance M	ding 12 for additional details anonymous staff members ins to ED A. It was confirmed tout the allegations of abuse if not reported or investigated in annual training records, realed each employee had or annual training on the integlect, resident rights, and in an understanding and reation laws and requirements, and Medicare program. The protection of the integlect is an understanding and reation laws and requirements are and federal requirements cilities for licensure. The communication with ED are activities, personnel or and other related topics. The relationships with state ry agencies, and works to attorn to description revealed: It is a support of the communication in the state ry agencies, and works to attorn to description revealed: It is an an an an an an an additional in the relationships with state ry agencies, and works to attorn to revealed: It is an an an an an an an an an additional in the relationships in	F 609		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL1 A. BUILDI	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		435086	B. WING _			C 01/08/2025
	ROVIDER OR SUPPLIER W HEALTHCARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 611 EAST 2ND AVE FLANDREAU, SD 57028	DE	0.100,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 609	grievances through to any necessary investederal and state regulations as they applicated and state regulations as they applicated and state regulations as they applicated and state regulation and state regulation of processary to prohibit neglect, including but training, prevention, reporting/response. On the compliance and Ethicated and Ethicated and Ethicated and Ethicated and state and sta	o their conclusion, leading tigations, and complying with relations and company to the grievance process. Or: Oversee the policies and procedures and prevent abuse and to not limited to: screening, identification, protection, and Coordinate abuse and s.  Son: Oversee the facility ics Program. Coordinate are compliance and volunteer compliance are Code of Conduct, HIPAA ortability and Accountability or mandatory compliance	F	609	)	
	your Regional Vice F Nurse Consultant im *"4. If abuse, negl- resident is suspected the resident from add *"8contact the soon as possible dur timeframe." *"9. Notify the reside of the suspected or a	President and/or Regional mediately."  ect, or exploitation of a d, act immediately to protect ditional harm."  appropriate State agency as ring the required reporting  nt's family/significant other(s)				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		435086	B. WING		01/08/2025
	ROVIDER OR SUPPLIER W HEALTHCARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	1 01100/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 609	Ombudsman, Adult I and/or the local polic *"13. A staff meml state agency of susp neglect, or exploitation It is the responsibility compliance with state reporting regulations.  16. Review of the professional Freedom from Abuse Punishment, Involunt	to call the Long-Term Care Protective Services Offices, i.e." Deer may notify the appropriate Dected/alleged abuse, On without fear of retribution. If of each employee to assure the abuse or suspected abuse to assure the abuse of suspected abuse	F 60	09	
	*Definitions: -"Mandatory Reporte employee, manager contractor of a Medinursing facility" -"Immediately: Mean absence of a shorter requirement, but not allegations is made, allegation involve abinjury or not later that cause the allegation not result in serious clock time)" *Procedure: -"7. Reporting and immediately reports allegations of abuse residents,mistreat unknown source in a federal law."	er: Anyone who is an agent, operator, owner, or care or Medicaid certified as as soon as possible, in the State time frame later than 2 hours after the if the events that cause the cuse or result in serious bodily in 24 hours if the events that do not involve abuse and do bodily injury. (Based on real			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С		
		435086	B. WING _			01/	08/2025
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER		61	TREET ADDRESS, CITY, STATE, ZIP CODE  1 EAST 2ND AVE  LANDREAU, SD 57028		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD B		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	Federal and State recoprevent, identify, investigate law, not to exceptional and state recoprevent. As a state law, not to exceptional and state law, not to except law, no	the Center complies with quirements to screen, train, stigate, protect, and report eatment, exploitation, and esident property."  ons involving mistreatment, luding injuries of unknown and misappropriation of reported immediately to the ED) and to other officials in eral and State law. estigations are reported to ignated representative and cordance with Federal and ed five working days of the correct Alleged Violation (4)  se to allegations of abuse, or mistreatment, the facility vidence that all alleged hly investigated.  It further potential abuse, or mistreatment while the		609	See next page		
	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective	the results of all administrator or his or her ative and to other officials in a law, including to the State of 5 working days of the aged violation is verified a action must be taken.					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
						(	C
		435086	B. WING			01/	08/2025
	ROVIDER OR SUPPLIER  W HEALTHCARE CENTE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	by: Based on South Dak (SD DOH) complaint document review, and failed to thoroughly in physical, mental, and nursing assistant (CN sampled residents (7 Findings include:  1. IMMEDIATE JEOP Notice of immediate j verbally and in writing p.m. to director of nur director of clinical ope to failure to report alle removal of the immed On 1/8/25 at 4:30 p.m written plan for the re jeopardy. The remova after 4:30 p.m. on 1/8 the removal plan for R p.m. included action i allegations of abuse t "F610. The provider la regarding the care an providing to residents p.m. The provider fail from potential further investigation by allow an overnight shift fror around 7:30 a.m. on get more information understand the exten provider failed to repo	tota Department of Health intake review, interview, d policy review, the provider ovestigate allegations of verbal abuse by certified IA) J towards two of seven and 9).  PARDY NOTICE eopardy at F610 was given g via email on 1/8/25 at 3:57 rsing (DON) B and division erations (DDCO) C relating egations of abuse. A plan for diacy was requested.  In., DDCO C emailed a moval of the immediate all plan was approved soon 1/25. It was determined that 1-600 sent on 1/7/25 at 12:56 tems to report the 1/20 to the required entities.  In earned about concerns and services a CNA was a on 1/1/25 at around 1:30 red to protect the residents abuse during the 1/2/25. The provider failed to from the reporting party to to of the situation. The 1/2 or the incidents to the 1/2 or the provider conducted an	F		<ol> <li>For residents 7 and 9 appropriate staff men were put on administrative leave. Reside were interviewed and felt safe in their en ment or didn't recall.</li> <li>Residents were interviewed to determine if had occurred, issues identified were resc Residents unable to be interviewed had cal exam completed by a LN to rule out a No issues were identified.</li> <li>The DDCO educated DNS on 1/6/2025 on Abuse, Neglect or Exploitation Policy, Fr from Abuse, Neglect, Corporal Punishme voluntary Seclusion, Mistreatment of Res Property, and Exploitation Policy, Abuse tion Policy and Abuse Investigation Policy DNS or designee educated all staff on the Abuse, Neglect or Exploitation Policy, Fr from Abuse, Neglect, Corporal Punishme voluntary Seclusion, Mistreatment of Res Property, and Exploitation Policy, and Ab Prohibition Policy by 1/10/2025 or prior to next working shift.</li> <li>The DDCO or designee will reiew all facility gations times two months to ensure they federal guidelines. (LP 2/5/2025) The ED designee will interview four random resid weekly times four weeks and monthly tim months to ensure residents have no congarding their care, have any signs of abuglect noted, and if they feel safe in their ement, if abuse/neglect is suspected alleg be reported and thoroughly investigated. DNS or designee will bring the results of dits to the monthly QAPI meeting for furtiview and recommendation to continue or tinue the audits.</li> </ol>	abuse blved. a physiabuse.  the eedoment, Insident Prohibisy. The eedoment, Insident of their prohibisy of their prohibisity of their prohibisy of their prohibisity of their prohibisy of their prohibisity of t	1/9/2025

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		435086	B. WING _			01/	08/2025
NAME OF PE	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ALUEALTUCADE CENTE			6	311 EAST 2ND AVE		
RIVERVIE	W HEALTHCARE CENTE	:K		F	FLANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 610	Continued From page	e 42	F6	310			
	assessing the resider nothing was documer	nts involved for injuries but nted.					
	The CNA has been so	uspended as of 1/6/2025					
		. The initial report to DOH					
		/2025. All residents had a					
	skin assessment com	pleted and any residents					
		erview for Mental Status]					
	_	been interviewed regarding					
		se by 11 am. A total of 49					
		ewed with no concerns, 1					
		rn that was reported to DOH					
		ts with a BIMS below eight,					
		was contacted, seven with					
		were left a voicemail. The					
	reporting party has ha investigation/interview						
		on 1/7/2025 by [ED A].					
		vided by [DDCO C] to [ED A					
		is validating documentation					
		in or affected body parts for					
	•	om nursing, day shift 4,					
		shift 1; dietary, one from					
	days and one from ev	•					
	activities, therapy and	HR across all shifts have					
	been interviewed rega	arding if they have ever seen					
	another staff member	abuse or neglect a resident					
	in any way on 1/7/202	25, no concerns noted.					
	Primary witness state	ments from other CNAs					
		leged perpetrator kick a					
	resident in the shin tw	vice, and a separate incident					
	with a different reside	nt where the alleged					
	perpetrator put a was	hcloth over a resident's					
		sident. Both those residents					
		ments from staff indicate					
		ongoing issue and the					
		nproves their actions for a					
	short while after being	g talked to by administration,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		435086	B. WING _			C <b>01/08/2025</b>
	NAME OF PROVIDER OR SUPPLIER  RIVERVIEW HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 611 EAST 2ND AVE FLANDREAU, SD 57028	DE	01/03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 610	but then slips back in serious concern that a potentially re-offend.  The CNA's making the interviewed and a rebeen conducted by [Esuspended 1/6/2025]  The two residents in physical harm, unable harm due to cognition on alert charting for 7.  The [perpetrator] had completed on 10/11/2 abuse.  The provider needs to prevent further potent The provider failed to required entities, allow to work a shift following abuse, failed to follow the The event was report educated [ED A and I abuse reporting, suspenses.	to their old ways. There is the alleged perpetrator will e alleged perpetrator will e allegation have been enactment of events has ED A]. The perpetrator was pending investigation.  Equestion] were assessed for e to assess for psychosocial e status. Both were placed 2 hours.  In a background check e to 23 with negative results for the tale immediate action to the tale abuse from occurring. The report the incidents to the wed the alleged perpetrator ing the report of alleged uct a thorough investigation, eir abuse/neglect policy.  The properties of the second perpetrator in the report of alleged uct a thorough investigation, eir abuse/neglect policy.  The properties of the second perpetrator in the report of alleged uct a thorough investigation, eir abuse/neglect policy.	F 6			
	policy on 1/7/2025 an Grievances for [the la	ated on the facility abuse d prior next working shift. st] 30 days were reviewed egations on 1/7/2025.				
	[Nurse's] notes for res	sidents were reviewed for				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		435086	B. WING _			C 01/08/2025
	ROVIDER OR SUPPLIER W HEALTHCARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	1	117072020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 610	Continued From pag	e 44	F 6	10		
	the last 30 days for p 1/7/2025.	ossible abuse allegations on				
	1/07/25 and the Med the alleged deficient Called at 10 AM by [ The immediacy at F6 been removed on 1/1 review. After remova	ity assurance and ement] is being completed ical Director was informed of practice and current plan. DON B]."  510 was determined to have 7/25 at 4:30 p.m. after onsite I of the immediacy, the				
	severity and scope was 62.	ras a level G.				
		ings 2 and 3 for information omplaint intake forms.				
	director (ED) A reveate *He denied that any of abuse or neglect at *However, when ask CNA J allegedly having held a cloth of the confirmed he had allegations.  -He explained that the forward those allegate could not describe sydone.  *The allegations were 4. Interview on 1/6/2	5 at 6:30 p.m. with executive aled: staff had reported allegations against any other staff. ed specific questions about ng kicked a resident and ver another resident's mouth, been aware of those e staff member who brought tions was nondescript and pecifically was CNA J had e not investigated further. 5 at 6:35 p.m. with DON B investigation process				
	revealed:	they were aware of the				

AND DLAN OF CORRECTION IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
						С	
		435086	B. WING			01/	08/2025
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 11 EAST 2ND AVE LANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	*As part of the investiresidents on different had any concerns wit receivingShe talked to three managements and are not afraitorThose residents had a time and are not afraitorThey felt that 3 of 62 sampleShe did not document and a time and are not afraitorShe did not document and a time and are not afraitorShe did not document and a time and are not afraitorShe did not document and a time and a	gation, DON B interviewed hallways to gauge if they hallways to gauge in the gauge in the gauge in the gauge in the gauge	F	610			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		435086	B. WING		C 01/08/2025	
	NAME OF PROVIDER OR SUPPLIER  RIVERVIEW HEALTHCARE CENTER			TREET ADDRESS, CITY, STATE, ZIP CODE 11 EAST 2ND AVE ELANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 610	incidentsIt was her expectal have been taken se should have been in 18. Refer to F600 fin regarding when the brought their conce that ED A learned a on 12/30/24 and hat the incidents.  9. Review of the proof Nursing Services revealed: *"Job summary: Is of Executive Director operations, activitic care staff, as gover and state and feder *"Essential Function2. Manages, sup of action for assign monitoring and follor6. Demonstrates knowledge of certific survey requirement8. Validates that consistently meet so for long-term care for10. Maintains op regarding resident of staffing problems, and 10. Review of the proof of the pro	tion that all allegations should briously, and the allegations investigated thoroughly.  ding 12 for additional details anonymous staff members rns to ED A. It was confirmed bout the allegations of abuse in doubt the allegations of abuse in the allegations in the all	F 610			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		435086	B. WING		C 01/08/2025	
	ROVIDER OR SUPPLIER W HEALTHCARE CEN	TER	6	TREET ADDRESS, CITY, STATE, ZIP CODE 11 EAST 2ND AVE ELANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 610	licensure.  -3. Human Resourc e. Ultimately ac staffing of the Center of the Ce	e Management countable for the adequate er. e within Federal and State blicies and processes. management style that any's core mission, values, ids department managers to inagement fficial: Responsible for vance process. ude: receiving and tracking to their conclusion, leading stigations, and complying with gulations and company only to the grievance process. tor: Oversee the colicies and procedures it and prevent abuse and out not limited to: screening, identification, protection, and Coordinate abuse and ons. ison: Oversee the facility nics Program. Coordinate or, and volunteer compliance one Code of Conduct, HIPAA cortability and Accountability er mandatory compliance on, and Abilities State Nursing Center rules and	F 610			
	laws."	plicable Federal and State g 20, 21, 22, and 23 for the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		435086	B. WING		01/	08/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/1	00/2023
RIVERVIE	W HEALTHCARE CENTE	ER		611 EAST 2ND AVE FLANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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 610 F 835 SS=E	provider's policies on investigation. Administration CFR(s): 483.70  §483.70 Administration A facility must be adnenables it to use its refficiently to attain or practicable physical, well-being of each restricted by execution of the provider of the prov	Abuse prohibition and  on.  ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident.  is not met as evidenced  tota Department of Health intake review, interview, d policy review, the provider acility was operated and estive director (ED) A and ON) B in a manner that and overall well-being of all 62 y. Those areas included: tive abuse and neglect mat included following res related to mandatory gations of all allegations of regations of physical, verbal, certified nursing assistant of sampled residents (7 and residents' (1, 3, and 6) right ue to anonymous staff or cellphone to secretly	F 610		abuse olved. a physiabuse.  the reedom ent, Insident Prohibible. The listed  i-weekly e sup-(LP 2/5/will inters four ensure leir care, and if use/ne-wired and or lits to the and	1/23/2025

PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 835 Continued From page 49 and DON B had not ensured the safe management and overall well-being of residents who lived in the facility. This was evidenced by a		NT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  RIVERVIEW HEALTHCARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 835  Continued From page 49 and DON B had not ensured the safe management and overall well-being of residents who lived in the facility. This was evidenced by a			435086	B. WING			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 835 Continued From page 49 and DON B had not ensured the safe management and overall well-being of residents who lived in the facility. This was evidenced by a				STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE		01/08/2025	
and DON B had not ensured the safe management and overall well-being of residents who lived in the facility. This was evidenced by a	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
implemented:  *An effective abuse prohibition program that included monitoring, reporting, investigating, and preventing alleged staff-to-resident abuse.  *An effective system to uphold resident rights, including the right to privacy.  Interview on 1/6/25 at 5:28 p.m. with DON B revealed that she initially denied any knowledge of recent allegations of staff-to-resident abuse.  Interview on 1/6/25 with anonymous staff member M revealed that they had secretly recorded resident conversations to have proof and show management that the residents had concerns regarding their care. Anonymous staff member M confirmed that they shared a recording with ED A.  Interview on 1/6/25 at 6:30 p.m. with ED A revealed that he initially denied any knowledge of recent allegations of staff-to-resident abuse.  Continued interview on 1/6/25 at 6:35 p.m. with ED A and DON B revealed they confirmed they had been aware of the allegations of staff-to-resident abuse.  Continued interview on 1/6/25 at 6:35 p.m. with ED A and DON B revealed they confirmed they had been aware of the allegations of staff-to-resident abuse by CNA J towards residents 7 and 9. Neither ED A nor DON B reported the allegations of abuse to the required entities. Their investigation was not thorough in that other staff were not initially interviewed to understand the whole story, the residents affected were allegedly assessed for physical injury but there was no documentation to support this, and 3 of 62 total residents were interviewed	F 835	and DON B had not management and ow who lived in the facil system breakdown to implemented:  *An effective abuse pincluded monitoring, preventing alleged standard to line with the regarding the right to line with the regarding their care. Confirmed that they resident conversation management that they sell the standard that they sell the standard the staff-to-resident abusinessed that the allegation of the staff-to-resident abusinessed the staff-to-resident abusinessed the staff were understand the whole affected were allegerinjury but there was sellegerinjury but there was sellegering in the staff were understand the whole affected were allegerinjury but there was sellegering in the staff were was sellegering in the staff were was sellegering in the staff were allegering by the staff were allegering by the staff were was sellegering in the staff were was sellegering in the staff were allegering by the staff were was sellegering in the staff were was sellegering with the staff were was sellegering w	ensured the safe gerall well-being of residents ity. This was evidenced by a consure they had  conhibition program that reporting, investigating, and taff-to-resident abuse. to uphold resident rights, privacy.  at 5:28 p.m. with DON B tially denied any knowledge of staff-to-resident abuse.  with anonymous staff member had secretly recorded has to have proof and show the residents had concerns Anonymous staff member M shared a recording with ED A at 6:30 p.m. with ED A ally denied any knowledge of staff-to-resident abuse.  on 1/6/25 at 6:35 p.m. with realed they confirmed they he allegations of se by CNA J towards the either ED A nor DON B ons of abuse to the required gation was not thorough in not initially interviewed to the story, the residents dly assessed for physical no documentation to support	F8	35		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		435086	B. WING _			01/	08/2025
NAME OF PROVIDER OR SUPPLIER  RIVERVIEW HEALTHCARE CENTER			6	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	Interview on 1/6/25 at revealed that register concerns about CNA on 1/1/25 at around 1 investigate the allegated day, and allowed CNA from 1/1/25 to the mopotentially put all residuates by CNA J. She provider's abuse and suspending staff pendinterview on 1/7/25 at director of clinical operation of the failure to follow the abuse and neglect prereporting, and investig ED A was supposed to abuse coordinator. Shallegations of abuse seriously, reported to the required timefram thoroughly. It was also aware of the secret reas anonymous staff mof the recordings to E. Interview on 1/8/25 w. N revealed that they recond the coordinate they recond to the coordinate they are conditioned to the recordings to E. Interview on 1/8/25 w. N revealed that they recond yet and 9 to ED A on 12/3 investigate those allegations of the provider they are conditioned to the coordinate they recond yet and 9 to ED A on 12/3 investigate those allegations of the provider they are conditioned to the provider they are conditioned to the coordinate they are condits the coordinate they are conditioned to the coordinate they are	umented.  7:04 p.m. with DON B ed nurse (RN) F reported J being rough with residents :30 p.m. DON B did not tions further until the next A J to work an overnight shift rning of 1/2/25, which dents at risk for further was not aware of the neglect policy on ding investigation.  2:21 p.m. with divisional erations (DDCO) C revealed on suspension related to the provider's policy regarding evention, prohibition, gating. She confirmed that to have been acting as the the confirmed that all should have been taken the required entities within the, and investigated to discovered that ED A was ecordings referenced above, thember M had emailed one D A.  ith anonymous staff member reported their concerns for aviors toward residents 7 80/24. ED A did not report or	F	835			
		ectly accountable to the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		С	
		435086	B. WING			01/	08/2025
NAME OF PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
DIVEDVIEW HEATTHCARE CENTER				6	11 EAST 2ND AVE		
RIVERVIEW HEALTHCARE CENTER			F	LANDREAU, SD 57028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	care staff, as governe and state and federal the nursing departme maintain high standar knowledgeable of ind and by implementing practices."  *"Essential Functions -1. Develops and mai philosophy, objective policy and process m6. Demonstrates a knowledge of certifica survey requirements,8. Validates that reconsistently meet staffor long-term care factured in the consistently meet staffor long-term care factured in the consistent in the consistent long-term care factured in the consistent long-term care factu	and success of the resident and success. Validates that and continues to develop and and of excellence by being ustry changes and trends, up-to-date nursing.  Intains a nursing service and sation laws and requirements, and Medicare program. And Medicare program. And Medicare program. Are porting departments and federal requirements are and federal requirements and incommunication with ED are activities, personnel or dother related topics.  And the success of the resident and success of the s	F	835			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		425000	B. WING			С	
		435086	b. WING	_		01/	08/2025
NAME OF PROVIDER OR SUPPLIER  RIVERVIEW HEALTHCARE CENTER			6	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	requirements for long licensure.  -3. Human Resourcee. Ultimately accountstaffing of the Centerf. Hire and manage laws, and Center policity pomote optimum per understanding of goatensistic level to promote optimum per understanding of goatensistic level level to promote optimum per vanda culture, and hold the same standards4. Compliance through to any necessary invest federal and state regulations as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as they apply -c. Abuse Coordinato implementation of policities as	der meets state and federal -term care Centers for  Management buntable for the adequate within Federal and State cies and processes. inications from be staff and vice versa to formance and ls. anagement style that my's core mission, values, se department managers to  gement cial: Responsible for ince process. de: receiving and tracking be their conclusion, leading igations, and complying with ulations and company to the grievance process. r: Oversee the licies and procedures and prevent abuse and not limited to: screening, dentification, protection, and coordinate abuse and s. on: Oversee the facility cs Program. Coordinate , and volunteer compliance e Code of Conduct, HIPAA rtability and Accountability mandatory compliance	F	835			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		435086	B. WING		0.	C 1/08/2025	
NAME OF PROVIDER OR SUPPLIER  RIVERVIEW HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028		1700/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 835	, ,		F8	35			
		ate Nursing Center rules and cable Federal and State					
	Refer to F583, F600,	F609, and F610.					