STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING _____ B. WING _____	C 01/08/2025

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RIVERVIEW HEALTHCARE CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 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 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 3:57 p.m., two additional immediate jeopardies were identified related to failure to report alleged abuse at F609 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 000		
F 583	Personal Privacy/Confidentiality of Records	F 583	See next page	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Lourdes Parker | 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.

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F 583 SS=D	Continued From page 1 CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint intake review, interview,	F 583	1. 1. Resident 1,3 and 6 voice recordings were permanently deleted from the device used for recording. CNA M was terminated from the facility on 1/9/2025. 2. Staff members were interviewed regarding using recordings on phone on 1/7/2025, issues identified were resolved. 3. The DDCO and DNS reviewed HIPAA and residents' rights in Code of Conduct. The DNS or designee educated staff on HIPAA, and a resident's right to privacy prior to 1/10/2025. Staff not in attendance will be educated prior to their next working shift. 4. The DNS or designee will interview 4 random staff weekly times four weeks and monthly times two months to determine understanding of HIPAA and residents' rights. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	1/25/2025

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F 583	Continued From page 2	F 583		

document review, and policy review, the provider failed to uphold a resident's right to personal privacy for at least 3 of 62 residents (1, 3, and 6) due to anonymous staff member M using their cellphone to secretly record private resident conversations.
Findings include:

1. Review of the SD DOH complaint intake form dated 12/31/24 revealed:
*The SD DOH received an email on 12/27/24 detailing allegations of abuse by certified nursing assistant (CNA) J.
*The sender explained that there were several audio recordings of private resident conversations detailing the abuse.
-The report specifically mentioned audio recordings of residents 1 and 6.

2. Interview on 1/6/25 at 5:28 p.m. with director of nursing (DON) B about the allegations revealed that she denied any recent allegations of abuse or neglect by staff.

3. Interview on 1/6/25 with anonymous staff member M revealed:
*Anonymous staff member M was concerned with the care that CNA J was providing.
*While anonymous staff member M was talking to residents about the abuse they were allegedly experiencing, they used their cellphone to secretly record what the residents were saying.
*Anonymous staff member M decided to record the conversations "for my own self" to gather evidence to present to administration.
*Anonymous staff member M had two or three recordings of residents 1, 3, and 6.
*Anonymous staff member M allegedly showed one of the recordings to executive director (ED)

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A, but they could not remember when.

4. Interview on 1/6/25 at 6:30 p.m. with ED A about the above allegations revealed:
*He initially denied that any staff members came to him recently with allegations of abuse against other staff.
*When asked more pointed questions about specific incidents, he confirmed a staff member "had come in and said, 'Well I think you should talk to her [CNA J], she is being rough.'"
*He explained that the staff member was giving nondescript things and could not describe exactly what CNA J was doing.
*ED A did not mention anything about the audio recordings.

5. Interview on 1/7/25 at 2:21 p.m. with divisional director of clinical operations (DDCO) C about the above information revealed:
*She expected all reports of suspected abuse to be taken seriously and handled immediately, including reporting to the required entities and launching a thorough investigation according to the abuse and neglect policy.
*Anonymous staff member M was placed on suspension pending investigation related to secretly recording resident conversations.
*Recording resident conversations was against the Federal Health Insurance Portability and Accountability Act (HIPAA), the company's code of conduct, and the employee handbook.
*They required anonymous staff member M to determine who they sent the recordings to, delete the recordings from their phone, delete the recordings from the deleted folder, and delete the recordings from all other devices.

6. Interview on 1/8/25 with anonymous staff

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member N revealed:
*Anonymous staff member N was with anonymous staff member M when they went to ED A about the allegations of abuse.
*Anonymous staff member N was aware of the voice recordings that anonymous staff member M had made.
*Anonymous staff member N said, "[Anonymous staff member M] wasn't recording the conversations out of malice, [they were] doing it to try to get proof because [they don't] believe that [ED A] would believe [it]."
-Anonymous staff member N confirmed that the recordings were shared with ED A.
*Anonymous staff members M and N went to ED A with their concerns on 12/30/24 around lunchtime.

7. Review of the provider's March 2012 CNA Job Description revealed:
*"Job Summary: ...The CNA is expected to perform duties in compliance with state and federal regulations."

8. Review of the provider's September 2023 Employee Handbook revealed:
*Page 7: "Guided by Ethics. Ethical integrity is the foundation of our actions, guiding us to make responsible, transparent, and morally sound decisions for the benefit of our patients, staff, and communities."
*Page 9, under the Resident Rights section: "Residents have the following rights under Federal law:
-Rights Related to Privacy and Resident Records
--1. To general privacy, including privacy in your personal care, medical treatments, telephone use, visits, letters, and meetings of family and resident groups."

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F 583	Continued From page 5 *Starting on page 57, under the Standards of Conduct section: "To meet resident's needs promptly and efficiently, our mission is to establish and maintain the highest standards of excellence in healthcare. To protect ...its residents ...the following standards have been established ... -1. Employees are expected to comply with the [company's] Code of Conduct. - ...10. Employees will immediately report to the Executive Director any of the following: resident abuse or neglect ... dishonesty ... Confidentiality shall be protected whenever possible. -11. Employees will adhere to positive ethical standards of the highest level in communication and behavior." *Starting on page 58: "The following list ...sets forth examples of conduct that will result in disciplinary action, including possible termination of employment: - ...12. Resident abuse or neglect or misappropriation of resident property. - ...22. Violation of health or safety rules applying to both residents and employees. - ...24. Conduct of an abusive or harassing nature whether verbal, mental or physical. - ...29. Immoral, inappropriate, or indecent conduct ..." *Starting on page 75, under the Cell Phones, Smart Phones, Tablets, & Other Handheld Devices section: -"Employees are ...prohibited from using handheld devices for personal purposes during working hours except in an emergency. -Employees are not allowed to use personal handheld devices in resident care areas and direct care staff is prohibited from having their personal cell phones on while providing resident care.	F 583		

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-Employees may not use a handheld device in a manner that violates ...any other Company policy.
-Recording Devices: To maintain the security of our premises and systems, and the privacy of our employees and residents, the Company prohibits unauthorized photography and audio or video recording of its employees, confidential documents, or residents.
--This prohibition includes the use of handheld devices equipped with cameras and audio and video recording capabilities."

9. Review of the provider's 2023 Code of Conduct revealed:
*Page 2, "Guided by Ethics. Ethical integrity is the foundation of our actions, guiding us to make responsible, transparent, and morally sound decisions for the benefit of our patients, staff, and communities."
*Page 6, "All Covered Persons and Covered Contractors must report suspected violations following the Reporting Process as well as comply with any federal, state and local reporting obligations, and [company's] policies."

10. Review of anonymous staff member M's personnel file revealed:
*They signed an "Acknowledgement and Agreement" form on 8/3/24 indicating they acknowledged the receipt of a copy of the Employee Handbook, as well as their understanding and acceptance of the contents within.
*They signed the "Code of Conduct Acknowledgement" on 8/3/24, certifying that they received the Code of Conduct document and agreeing to abide by the policies and principles.
*On 8/3/24, they were oriented and trained on all the required training topics, including resident

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F 583	Continued From page 7 rights, HIPAA, and abuse prohibition. 11. Review of CNA J's personnel 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. 12. Review of anonymous staff member N's employee file revealed they were trained on all the required training topics on 12/6/23, including resident rights and abuse prohibition. 13. Review of the provider's November 2019 Executive Director job description revealed: *"Essential Functions -4. Compliance Management -- ...d. Compliance Liaison: Oversee the facility Compliance and Ethics Program. Coordinate employee, contractor, and volunteer compliance training to include the Code of Conduct, HIPAA [Health Insurance Portability and Accountability Act] policy, and other mandatory compliance policies. --e. Privacy Officer: Oversee the implementation, maintenance of, and adherence to privacy policies and procedures regarding the safe use and handling of protected health information (PHI) in compliance with federal and state HIPAA regulation."	F 583		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600	See next page	

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F 600	Continued From page 8 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint intake review, interview, document review, and policy review, the provider failed to protect two of seven sampled residents' (7 and 9) right to be free from physical, mental, and verbal abuse by certified nursing assistant (CNA) J. Findings include: 1. IMMEDIATE JEOPARDY NOTICE Notice of immediate jeopardy was given verbally and in writing via email on 1/6/25 at 8:32 p.m. to executive director (ED) A, director of nursing (DON) B, and over the phone to division director of clinical operations (DDCO) C for F600 related to allegations of physical, mental, and verbal abuse that several staff had reported with no actions taken to protect the residents from further potential abuse. A plan for removal of the immediacy was requested. On 1/7/25 at 10:20 a.m., DDCO C provided a written plan for removal of the immediate jeopardy via email. The removal plan, after agreed-upon revisions, with guidance from the long-term care advisor for the SD DOH, was approved on 1/7/25 at 12:56 p.m.:	F 600	1. For residents 7 and 9 appropriate staff members were put on administrative leave. Residents were interviewed and felt safe in their environment or didn't recall. 2. Residents were interviewed to determine if abusehad occurred, issues identified were resolved. Residents unable to be interviewed had a physical exam completed by a LN to rule out abuse. No issues were identified. 3. The DDCO educated DNS on 1/6/2025 on the Abuse, Neglect or Exploitation Policy, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment of Resident Property, and Exploitation Policy, Abuse Prohibition Policy and Abuse Investigation Policy. The DNS or designee educated all staff on the Abuse, Neglect or Exploitation Policy, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment of Resident Property, and Exploitation Policy, and Abuse Prohibition Policy by 1/10/2025 or prior to their next working shift. 4. The ED/DNS or designee will interview four random residents', and four family members (LP 2/4/2025) weekly times four weeks and monthly times two months to ensure residents have no concerns regarding their care, have any signs of abuse/neglect noted, and if they feel safe in their environment, if abuse/neglect is suspected allegation will be reported and thoroughly investigated. The ED/DNS or designee will bring the results of the audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	1/9/2025

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"F600. The provider learned about concerns regarding the care and services a CNA was providing to residents on 1/1/25 at around 1:30 p.m. The provider failed to protect the residents from potential further abuse during the investigation by allowing the CNA to keep working an overnight shift from 10:30 p.m. on 1/1/25 to around 7:30 a.m. on 1/2/25. The provider failed to get more information from the reporting party to understand the extent of the situation. The provider failed to report the incidents to the necessary entities. The provider conducted an investigation into the allegations including assessing the residents involved for injuries but nothing was documented.

The CNA has been suspended as of 1/6/2025 pending investigation. The initial report to DOH was submitted on 1/6/2025. All residents had a skin assessment completed and any residents with a BIMS [Brief Interview for Mental Status] above an eight have been interviewed regarding any potential for abuse by 11 am. A total of 49 residents were interviewed with no concerns, 1 resident with a concern that was reported to DOH this morning, residents with a BIMS below eight, the responsible party was contacted, seven with no concerns and five were left a voicemail. The reporting party has had a thorough investigation/interview with re-enactment completed by 10 am on 1/7/2025 by [ED A]. Abuse education provided by [DDCO C] to [ED A and DON B] as well as validating documentation in place to monitor skin or affected body parts for injury. Several staff from nursing, day shift 4, evening shift 2, night shift 1; dietary, one from days and one from evening; maintenance, activities, therapy and HR across all shifts have

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been interviewed regarding if they have ever seen another staff member abuse or neglect a resident in any way on 1/7/2025, no concerns noted.

Primary witness statements from other CNAs who witnessed the alleged perpetrator kick a resident in the shin twice, and a separate incident with a different resident where the alleged perpetrator put a washcloth over a resident's mouth to quiet the resident. Both those residents have dementia. Statements from staff indicate that this has been an ongoing issue and the alleged perpetrator improves their actions for a short while after being talked to by administration, but then slips back into their old ways. There is serious concern that the alleged perpetrator will potentially re-offend.

The CNA's making the allegation have been interviewed and a re-enactment of events has been conducted by [ED A]. The perpetrator was suspended 1/6/2025 pending investigation.

The two residents in [question] were assessed for physical harm, unable to assess for psychosocial harm due to cognition status. Both were placed on alert charting for 72 hours.

The [perpetrator] had a background check completed on 10/11/2023 with negative results for abuse.

The provider needs to take immediate action to prevent further potential abuse from occurring. The provider failed to report the incidents to the required entities, allowed the alleged perpetrator to work a shift following the report of alleged abuse, failed to conduct a thorough investigation, and failed to follow their abuse/neglect policy.

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The event was reported 1/6/2025. [DDCO C], educated [ED A and DON B] on abuse policy, abuse reporting, suspension pending investigation and investigation by 1/6/2025 via phone.

All staff were re-educated on the facility abuse policy on 1/7/2025 and 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.

An Ad hoc [meaning "when necessary or needed"] QAPI [quality assurance and performance improvement] is being completed 1/07/25 and the Medical Director was informed of the alleged deficient practice and current plan. Called at 10 AM by [DON B]."

On 1/7/25 at 4:30 p.m., the survey team determined the immediacy was removed. After removal of the immediacy, the severity and scope was a level G.

The census was 62.

2. Review of the SD DOH complaint intake form dated 12/31/24 revealed:
*The SD DOH received an email on 12/27/24 detailing allegations of abuse by CNA J. They wanted to remain anonymous.
*The complainant claimed to have reported CNA J to management previously.
-" ...she [CNA J] got talked to and [had her work]

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hours cut, after getting talked to before, she would be good only for a week if that before she continued her verbal and physical abuse."
*The complainant described a witnessed incident involving resident 7 and CNA J. The complainant did not mention a date.
-Resident 7 was non-verbal.
-The complainant and CNA J were transferring resident 7 using a full-body mechanical lift.
-CNA J "slammed a cloth over [resident 7's] mouth" and held it there with her fingertips.
-The complainant felt as if CNA J did that as a means to quiet the resident.
*The complainant described another witnessed incident involving resident 9 and CNA J. The complainant did not mention a date.
-Resident 9 had dementia and tended to reach out to people walking by to hold their hand.
-Resident 9 was sitting in her wheelchair in the hallway next to anonymous staff member N.
-Resident 9 reached out towards CNA J as she was walking past and said, "Hey come here quick."
-CNA J was witnessed to have kicked resident 9 twice in the shin.

3. Review of an additional SD DOH complaint intake form dated 1/6/25 revealed:
*The SD DOH received an email on 1/3/25 from a different anonymous complainant.
*"There is a CNA that works here named [CNA J] and she is abusing residents."
*"I have witnessed her kicking, yelling and calling [them] names, which is mental abuse."
*"I have reported this to the administration to no avail."
*The complainant did not include any dates. They wished to remain anonymous.

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4. The survey team entered the facility on 1/6/25 at 4:15 p.m. and requested several items, including staff schedules. Review of the staff schedules revealed that CNA J was scheduled to work an overnight shift that night.

5. Interview on 1/6/25 at 5:28 p.m. with DON B revealed:
*She denied that any staff had reported allegations of abuse or neglect against any other staff.
*When questioned specifically about any knowledge of incidents involving a staff member kicking residents or holding a cloth over a resident's mouth, she denied any knowledge of such incidents.
*Refer to F600 findings 8 and 9 where DON B confirmed she was aware of the incidents.

6. Confidential interview on 1/6/25 with anonymous staff member M revealed:
*They were initially afraid to come forward with the allegations against CNA J, due to CNA J's retaliatory nature.
*During one incident, anonymous staff member M was assisting CNA J with transferring resident 7 using the full body mechanical lift.
-"[CNA J] put a cloth over [resident 7's] mouth."
-She held the cloth over the resident's mouth for about a minute.
-Anonymous staff member M perceived it to be forceful, as a way to quiet resident 7.
*During another incident, anonymous staff member M and another staff member witnessed CNA J kick resident 9 in the shin.
-"I brought [resident 9] into the hallway ... [Resident 9] reached her hand out to [CNA J] and [CNA J] kicked [resident 9] twice in the shin."
-They confirmed they witnessed this incident

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happen.
-Anonymous staff member M could not recall when the kicking incident occurred, but guessed it was within the last three to four weeks.
*They explained the reason why they did not report those incidents immediately was because previously when incidents were reported, CNA J's actions would improve for a short while, but then would return to the abusive behaviors.
*Anonymous staff member M confirmed that they and another staff member reported the above incidents to ED A.
-Anonymous staff member M could not remember when they reported those incidents to ED A.

7. Interview on 1/6/25 at 6:30 p.m. with ED A revealed:
*He denied that any staff had reported allegations of abuse or neglect against any other staff.
*However, when asked specific questions about CNA J allegedly having kicked a resident and having held a cloth over another resident's mouth, he confirmed he had been aware of those allegations.
-He explained that the staff member who brought forward those allegations was nondescript and could not describe specifically what CNA J had done.
*He explained that DON B would have completed an investigation regarding the alleged abuse, including performing resident assessments and educating staff.

8. Continued interview on 1/6/25 at 6:35 p.m. with ED A and DON B about the above incidents revealed:
*On 1/2/25, DON B had given CNA J a written warning "like your actions and how you hold

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yourself can be perceived different [differently] by others."
-CNA J had denied harming any residents.
*DON B indicated she interviewed other residents (residents 2, 8, and 10) to see if they had any concerns regarding abuse or neglect. None of the residents she talked to expressed concerns.
-She did not document any of those interviews as part of the investigation.
*They confirmed there had been no other documented disciplinary actions against CNA J during her employment with the provider.

9. Interview on 1/6/25 at 7:04 p.m. with DON B revealed:
*She conducted a visual inspection of residents 7 and 9 on 1/2/25 prior to speaking with CNA J about the allegations.
*Resident 9 was not able to verbalize if she remembered the incident or not.
*Resident 9 was still in her nightgown, so DON B looked at her legs and did not see any bruising.
-The resident did not act any differently.
*DON B confirmed she did not follow-up with resident 7 "as much."
-"I laid eyes on her. [Resident 7] does not like to be talked to. I did not engage with [resident 7]. I did an up-close assessment and checked on her."
-She confirmed the assessment of resident 7 was face-to-face. Resident 7 was under her bed covers, but the room light was on, so she was able to visualize resident 7's mouth and nose area.
-She did not notice any redness or other signs of trauma around the resident's mouth and nose.
*DON B confirmed she did not document those visual inspections.
-She was confused about what should have gone

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into a resident's medical chart versus "something more private like risk management" (the provider's system of electronically tracking incidents).
*She confirmed she learned about the allegations on 1/1/25 around 1:30 p.m. when registered nurse (RN) F contacted her about the allegations.
-RN F told her that staff had come forward with concerns.
-RN F did not provide any details about the concerns, and DON B did not ask further questions about the concerns.
*She did not contact ED A about the allegations until the morning of 1/2/25.
*DON B confirmed that CNA J worked from 10:30 p.m. on 1/1/25 to 7:30 a.m. on 1/2/25 after she learned of the allegations against the CNA.
-CNA J clocked back in at 12:08 p.m. on 1/3/25 and worked until around 2:00 p.m.
*DON B had never suspended any staff pending an investigation before.
-"I knew that I had to have a conversation with her [CNA J] and I felt that was the steps I needed to take."
-She had not considered suspending CNA J pending the investigation.
*DON B explained that she had been the DON since July 2024. She was the Minimum Data Set (MDS) Assessment coordinator prior to that.
-She indicated she had not received a lot of training when she took over the DON position.
-She was not aware that the above allegations required reporting.
*She was not aware of the Administrative Rules of South Dakota detailing what type of incidents were required to have been reported.
*She was not aware of the provider's abuse and neglect prohibition policy when it came to reporting and investigating allegations of abuse

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and neglect.
*She again confirmed the following:
-CNA J was not suspended pending investigation and was allowed to work an overnight shift prior to the investigation.
-The allegations of abuse were not reported to the required entities.
-The investigation was not documented.

10. Interview on 1/7/25 at 2:21 p.m. with DDCO C revealed:
*ED A was placed on suspension related to his failure to follow the provider's policy regarding abuse and neglect prevention and prohibition.
-He was supposed to have been acting as the abuse/neglect coordinator.

11. Interview on 1/8/25 at 9:53 a.m. with DON B and DDCO C revealed:
*At the time RN F called her on 1/1/25, DON B did not know the extent of the details of the alleged abuse, like the allegations that CNA J held a washcloth onto resident 7's mouth and kicked resident 9 in the shin.
-She was aware, however, of the allegations of CNA J having been potentially rough when providing care to residents.
*DDCO C explained that, to her understanding, the above incidents happened several weeks ago, and the witnesses came to ED A recently to report the incidents.
-It was her expectation that staff should have immediately reported the abuse.
-It was her expectation that all allegations should have been taken seriously, and the allegations should have been investigated thoroughly.
-She explained the investigation should have consisted of a root-cause analysis, the "5 Why's" should have been explored, and a scene

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reenactment should have been completed.

12. Confidential interview on 1/8/25 with anonymous staff member N revealed:
*The incident involving CNA J and resident 9 happened two to three weeks ago, but they could not remember exactly when that occurred.
*Resident 9 was sitting in her wheelchair in the hallway outside her room.
*Resident 9 tended to reach her hand out to people to grab them.
*Anonymous staff member N observed resident 9 reaching towards CNA J.
-CNA J kicked resident 9 twice on the right shin "hard enough that [resident 9] made a face about it ...but not hard enough to leave a bruise."
*Resident 9 looked sad and shocked. She was not very verbal, so resident 9 did not say anything about that incident.
*Anonymous staff member N also overheard CNA J say to resident 9, "You're an ugly gremlin. I can tell you've had a hard life. I can tell you probably smoked all your life."
*Anonymous staff member N wheeled resident 9 away from the situation afterward to see if she was okay.
*That event potentially happened at the beginning of December 2024, but anonymous staff member N was not sure.
*Anonymous staff member N did not report that incident to the nurse or to management at that time.
-Anonymous staff member N was aware they were required to report incidents like abuse immediately.
-Anonymous staff member N feared retaliation from CNA J.
*Anonymous staff members M and N finally reported their concerns to ED A on 12/30/24

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around lunchtime.
-Both anonymous staff members M and N were specific when detailing the alleged abuse to ED A and provided the specific incidents.
*On 1/1/25, they again reported the alleged abuse to RN F after no improvements were observed in CNA J's behavior towards residents.
-Anonymous staff member N confirmed they were very specific with details of the alleged abuse when reporting their concerns to RN F.

13. Interview on 1/8/25 at 12:09 p.m. with RN F revealed:
*She confirmed that two staff members reported CNA J's alleged abuse on 1/1/25.
*She denied that they were specific about the abuse allegations.
-"They did not specify exactly what happened that was rough."
*She confirmed that she called DON B immediately to report the concerns.

14. Review of resident 7's electronic medical record (EMR) revealed:
*She was admitted on 11/30/17.
*She had diagnoses including senile degeneration of brain, unspecified dementia, age-related cognitive decline, adult failure to thrive, anxiety disorder, and other recurrent depressive disorders.
*There was nothing in her EMR that indicated she had been assessed after the alleged abuse was reported.
*Her Brief Interview for Mental Status (BIMS) assessment score was 2 on the 12/11/24 quarterly MDS assessment, which indicated she was severely cognitively impaired.
*Her care plan indicated she was dependent on staff for ambulation, bathing, dressing, bed

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mobility, and eating.
-She 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 another individual.
*A "Disciplinary Action Form" completed by DON B on 1/2/25 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] that she needs to be thoughtful on how others perceive her actions [and] words. If behavior

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doesn't improve, written warning, probation, suspension procedure will be followed."

17. Review of the provider's March 2012 CNA job description revealed "the CNA is expected to perform duties in compliance with state and federal regulations."

18. Review of the provider's March 2012 Director of Nursing Services (DNS) job description revealed:
*"Job summary: Is directly accountable to the Executive Director (ED) for the day-to-day operations, activities, and success of the resident care staff, as governed by the Center policies, and state and federal regulations. Validates that the nursing department continues to develop and maintain high standards of excellence by being knowledgeable of industry changes and trends, and by implementing up-to-date nursing practices."
*"Essential Functions
-1. Develops and maintains a nursing service philosophy, objectives, standards of practice, policy and process manuals.
-2. Manages, supervises, and develops plans of action for assigned units, providing consistent monitoring and follow-through.
-3. Establishes systems for care planning, including assessments, plan of treatment, objectives and goals, evaluations, and discharge planning period maintains accurate and timely documentation reflecting same.
- ...6. Demonstrates an understanding and knowledge of certification laws and requirements, survey requirements, and Medicare program.
- ...8. Validates that reporting departments consistently meet state and federal requirements for long-term care facilities for licensure.

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F 600	Continued From page 22 - ...10. Maintains open communication with ED regarding resident care activities, personnel or staffing problems, and other related topics. - ...13. Understands the relationships with state and federal regulatory agencies, and works to maintain positive relationships." 19. Review of the provider's November 2019 Executive Director job description revealed: *"Job summary: The Executive Director (ED) is directly accountable ...to provide strong overall leadership and management of a long-term care center. Manages delivery of the highest level of health services and quality of care that is responsive to customers' needs." *"Essential Functions - ...2. Quality Management --a. Lead the process to develop and implement programs to maintain quality of care to meet established goals. --b. Responsible to maintain a safe, healthy, clean, and well-organized building that reflects a high standard of care and service. -- ...d. Verify the Center meets state and federal requirements for long-term care Centers for licensure. -3. Human Resource Management -- ...e. Ultimately accountable for the adequate staffing of the Center. --f. Hire and manage within Federal and State laws, and Center policies and processes. --g. Facilitate communications from administrative level to staff and vice versa to promote optimum performance and understanding of goals. -- ...j. Implement a management style that embodies the company's core mission, values, and culture, and holds department managers to the same standards.	F 600		

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F 600	Continued From page 23 -4. Compliance Management -- ...b. Grievance Official: Responsible for overseeing the grievance process. Responsibilities include: receiving and tracking grievances through to their conclusion, leading any necessary investigations, and complying with federal and state regulations and company policies as they apply to the grievance process. -c. Abuse Coordinator: Oversee the implementation of policies and procedures necessary to prohibit and prevent abuse and neglect, including but not limited to: screening, training, prevention, identification, protection, and reporting/response. Coordinate abuse and neglect investigations. --d. Compliance Liaison: Oversee the facility Compliance and Ethics Program. Coordinate employee, contractor, and volunteer compliance training to include the Code of Conduct, HIPAA [Health Insurance Portability and Accountability Act] policy, and other mandatory compliance policies." *"Knowledge, Skills, and Abilities -1. Familiarity with State Nursing Center rules and regulations, and applicable Federal and State laws." 20. Review of the provider's November 2019 Abuse, Neglect, or Exploitation policy revealed: *"1. Complaints of abuse, neglect, or exploitation are viewed as very serious and are reported to your Regional Vice President and/or Regional Nurse Consultant immediately." *"2. ...Abuse may be defined as an act by an individual which injures, exploits, or jeopardizes an individual's health, welfare, or safety, including, but not limited to: -Physically damaging or potentially damaging non-accidental acts (e.g. staff striking a resident).	F 600		

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F 600	Continued From page 24 -Emotionally damaging verbal behavior and harassment." *"3. Abuse, neglect, or exploitation can involve: ...One or more resident(s) and staff." *"4. If abuse, neglect, or exploitation of a resident is suspected, act immediately to protect the resident from additional harm." *"5. Act quickly to gather pertinent information. If an employee is suspected of the abuse, the employee is suspended pending the outcome of an investigation, for the employee's protection as well as the protection of the resident. -A staff person suspected or accused of abuse, neglect, or exploitation does not have access to any resident until the Community investigates and takes action to assure resident safety." *"6. Complete an Incident Report and make appropriate documentation in the resident's Service Notes." *"7. Initiate an investigation. Staff on duty at the time the alleged abuse occurred are interviewed prior to leaving their respective shift. This applies to staff as well as other residents in the area." *"8. ...contact the appropriate State agency as soon as possible during the required reporting timeframe." *"9. Notify the resident's family/significant other(s) of the suspected or alleged abuse." *"10. Depending on the type of incident, it may also be appropriate to call the Long-Term Care Ombudsman, Adult Protective Services Offices, and/or the local police." *" ...13. A staff member may notify the appropriate state agency of suspected/alleged abuse, neglect, or exploitation without fear of retribution. It is the responsibility of each employee to assure compliance with state abuse or suspected abuse reporting regulations." *"14. If a staff member reports a suspected or	F 600		

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alleged case of abuse, he/she is not retaliated against for making a good faith report. However, protection from retaliation does not prevent the Community from taking appropriate personnel action related to false reporting, policy violations, or performance deficiencies."

21. Review of the provider's October 2022 Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation policy revealed:
*"Policy Statement: each resident has the right to be free from abuse, including verbal, mental, ...or physical abuse ...
-The Center implements policies and processes so that residents are not subjected to abuse by staff ..."
*Definitions:
-"Abuse: The willful infliction of injury ...with resulting physical harm, pain, or mental anguish. 'Willful,' as used in this definition of abuse, means the individual acted deliberately, not that the individual must have intended to inflict injury or harm."
-"Mental Abuse: The use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. It includes but is not limited to ...harassment, ...and verbal assault that includes ridiculing, yelling, or swearing."
-"Verbal Abuse: May be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend or disability.
--Examples of mental and verbal abuse include,

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but are not limited to: Harassing a resident; mocking, insulting, ridiculing ..."
-"Physical Abuse: Includes, but is not limited to, hitting, slapping, punching, choking, pinching, biting, kicking throwing objects, grabbing, and shoving. Physical abuse also includes controlling or correcting behavior through corporal punishment."
-"Corporal Punishment: Inflicting physical pain or injury upon a resident. Physical punishment that is used as a means to correct or control behavior. Includes but is not limited to, pinching, spanking, slapping of hands, flicking, or hitting with an object."
-"Mistreatment: Inappropriate treatment or exploitation of a resident."
-"Mandatory Reporter: Anyone who is an employee, manager, agent, operator, owner, or contractor of a Medicare or Medicaid certified nursing facility..."
-"Staff: Staff includes employees, medical director, consultants, contractors and volunteers. Staff also includes caregivers who provide care and services on behalf of the Center ..."
-"Immediately: Means as soon as possible, in the absence of a shorter State time frame requirement, but not later than 2 hours after the allegations is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. (Based on real clock time)"
-"Serious Bodily Injury: Means an injury involving extreme physical pain ..."
-"Staff to Resident Abuse: Any form of abuse directed by staff to a resident."
*Procedure:
-" ...3. Prevention: The Center implements written

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policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation."
-"4. Identification: The Center implements written procedures to assist staff in identifying abuse, neglect, and exploitation of residents ..."
-"5. Investigation: The Center conducts a thorough investigation of potential, suspected and/or allegations of abuse, neglect, and exploitation of residents, misappropriation of resident property, mistreatment, and injuries of unknown source, in accordance with state and federal regulations."
-"6. Protection: The Center protects residents from physical and psychosocial harm during and after an investigation."
-"7. Reporting and Response: The Center immediately reports all suspected and/or allegations of abuse, neglect, and exploitation of residents, ...mistreatment, and injuries of unknown source in accordance with state and federal law."

22. Review of the provider's November 2016 Abuse Prohibition Notification policy revealed:
*"Policy Statement: The Center complies with Federal and State requirements to screen, train, prevent, identify, investigate, protect, and report abuse, neglect, mistreatment, exploitation, and misappropriation of resident property."
*" ...4. Alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, exploitation, and misappropriation of resident property, are reported immediately to the Executive Director (ED) and to other officials in accordance with Federal and State law.
-At the time of an alleged violation, an investigation is initiated.
-The alleged victim is protected to prevent harm

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during the investigation.
-The results of investigations are reported to the ED or his/her designated representative and to other officials in accordance with Federal and State law, not to exceed five working days of the incident."
*"5. Instances of disregard for the Center's policies and processes is cause for corrective action up to and including suspension, termination, and reporting to licensing agencies."

23. Review of the provider's October 2022 Abuse Investigation policy revealed:
*"Policy Statement: The Center conducts a thorough investigation of potential, suspected and/or allegations of abuse, neglect, and exploitation of residents, misappropriation of resident property, mistreatment, and injuries of unknown origin, in accordance with state and federal regulations."
*"1. The Executive Director is the designated abuse coordinator and is responsible for assigning and overseeing staff that are to assist with investigations."
*"2. The Center identifies and interviews involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations."
*"3. The Center protects the alleged victim during and after the course of the investigation."
*"4. Through investigation, the Center works to determine if the abuse, neglect, exploitation, misappropriation of property, and/or mistreatment has occurred and to determine the extent and cause.
*"5. The Center maintains complete and thorough documentation of the investigation."
*" ...7. The Center investigates patterns, trends, or events that suggest the possible presence of

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F 600	Continued From page 29 abuse, neglect, misappropriation of resident property, exploitation, mistreatment, and injuries of unknown source, identified through analysis conducted by the QAA [Quality Assessment and Assurance] Committee, with intervention, reporting, or policy/process modification conducted as appropriate."	F 600		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609	1.For residents 7 and 9 appropriate staff members were put on administrative leave. Residents were interviewed and felt safe in their environment or didn't recall. 2. Residents were interviewed to determine if abuse had occurred, issues identified were resolved. Residents unable to be interviewed had a physical exam completed by a LN to rule out abuse. No issues were identified. Progress notes and risk management are reviewed daily as part of the daily clinical meeting. (LP 2/5/2025). 3. The DDCO educated DNS on 1/6/2025 on the Abuse, Neglect or Exploitation Policy, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment of Resident Property, and Exploitation Policy, Abuse Prohibition Policy and Abuse Investigation Policy. The DNS or designee educated all staff on the Abuse, Neglect or Exploitation Policy, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment of Resident Property, and Exploitation Policy, and Abuse Prohibition Policy by 1/10/2025 or prior to their next working shift. 4. The ED/DNS or designee will interview four random residents', 2 staff and 2 family members(LP 2/4/2025) weekly times four weeks and monthly times two months to ensure residents have no concerns regarding their care, have any signs of abuse/neglect noted, and if they feel safe in their environment, if abuse/neglect is suspected allegation will be reported and thoroughly investigated. The ED/DNS or designee will bring the results of the audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	1/9/2025

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This REQUIREMENT is not met as evidenced by:
Based on South Dakota Department of Health (SD DOH) complaint intake review, interview, document review, and policy review, the provider failed to notify the required entities of allegations of physical, mental, and verbal abuse by certified nursing assistant (CNA) J towards two of seven sampled residents (7 and 9).
Findings include:

1. IMMEDIATE JEOPARDY NOTICE
Notice of immediate jeopardy at F609 was given verbally and in writing via email on 1/8/25 at 3:57 p.m. to director of nursing (DON) B and division director of clinical operations (DDCO) C relating to failure to report allegations of abuse. A plan for removal of the immediacy was requested.

On 1/8/25 at 4:30 p.m., DDCO C emailed a written plan for the removal of the immediate jeopardy. The removal plan was approved soon after 4:30 p.m. on 1/8/25. It was determined that the removal plan for F600 sent on 1/7/25 at 12:56 p.m. included action items to report the allegations of abuse to the required entities.

"F609. The provider learned about concerns regarding the care and services a CNA was providing to residents on 1/1/25 at around 1:30 p.m. The provider failed to protect the residents from potential further abuse during the investigation by allowing the CNA to keep working an overnight shift from 10:30 p.m. on 1/1/25 to around 7:30 a.m. on 1/2/25. The provider failed to get more information from the reporting party to understand the extent of the situation. The provider failed to report the incidents to the necessary entities. The provider conducted an

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investigation into the allegations including assessing the residents involved for injuries but nothing was documented.

The CNA has been suspended as of 1/6/2025 pending investigation. The initial report to DOH was submitted on 1/6/2025. All residents had a skin assessment completed and any residents with a BIMS [Brief Interview for Mental Status] above an eight have been interviewed regarding any potential for abuse by 11 am. A total of 49 residents were interviewed with no concerns, 1 resident with a concern that was reported to DOH this morning, residents with a BIMS below eight, the responsible party was contacted, seven with no concerns and five were left a voicemail. The reporting party has had a thorough investigation/interview with re-enactment completed by 10 am on 1/7/2025 by [ED A]. Abuse education provided by [DDCO C] to [ED A and DON B] as well as validating documentation in place to monitor skin or affected body parts for injury. Several staff from nursing, day shift 4, evening shift 2, night shift 1; dietary, one from days and one from evening; maintenance, activities, therapy and HR across all shifts have been interviewed regarding if they have ever seen another staff member abuse or neglect a resident in any way on 1/7/2025, no concerns noted.

Primary witness statements from other CNAs who witnessed the alleged perpetrator kick a resident in the shin twice, and a separate incident with a different resident where the alleged perpetrator put a washcloth over a resident's mouth to quiet the resident. Both those residents have dementia. Statements from staff indicate that this has been an ongoing issue and the alleged perpetrator improves their actions for a

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short while after being talked to by administration, but then slips back into their old ways. There is serious concern that the alleged perpetrator will potentially re-offend.

The CNA's making the allegation have been interviewed and a re-enactment of events has been conducted by [ED A]. The perpetrator was suspended 1/6/2025 pending investigation.

The two residents in [question] were assessed for physical harm, unable to assess for psychosocial harm due to cognition status. Both were placed on alert charting for 72 hours.

The [perpetrator] had a background check completed on 10/11/2023 with negative results for abuse.

The provider needs to take immediate action to prevent further potential abuse from occurring. The provider failed to report the incidents to the required entities, allowed the alleged perpetrator to work a shift following the report of alleged abuse, failed to conduct a thorough investigation, and failed to follow their abuse/neglect policy.

The event was reported 1/6/2025. [DDCO C], educated [ED A and DON B] on abuse policy, abuse reporting, suspension pending investigation and investigation by 1/6/2025 via phone.

All staff were re-educated on the facility abuse policy on 1/7/2025 and prior next working shift.

Grievances for [the last] 30 days were reviewed for possible abuse allegations on 1/7/2025.

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[Nurse's] notes for residents were reviewed for the last 30 days for possible abuse allegations on 1/7/2025.

An Ad hoc [meaning "when necessary or needed"] QAPI [quality assurance and performance improvement] is being completed 1/07/25 and the Medical Director was informed of the alleged deficient practice and current plan. Called at 10 AM by [DON B]."

The immediacy at F609 was determined to have been removed on 1/7/25 at 4:30 p.m. after onsite review. After removal of the immediacy, the severity and scope was a level G.

The census was 62.

2. Review of the SD DOH complaint intake form dated 12/31/24 revealed:
*The SD DOH received an email on 12/27/24 detailing allegations of abuse by CNA J. They wanted to remain anonymous.
*The complainant claimed to have reported their concerns to management previously. They did not include any dates about when the concerns were reported.
-"I reported [CNA J's] rudeness and 'roughness' prior, she would get talked [to] and [had her work] hours cut but within a week [she's] back to being rude and rough with the residents."
*See F600 finding 2 for details pertaining to the alleged abuse.

3. Review of an additional SD DOH complaint intake form dated 1/6/25 revealed:
*The SD DOH received an email on 1/3/25 from a different anonymous complainant.
*The complainant claimed to have reported their

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concerns to management previously. They did not include any dates about when the concerns were reported.
-"I have reported this to the administration to no avail."
*See F600 finding 3 for details pertaining to the alleged abuse.

4. Interview on 1/6/25 at 5:28 p.m. with DON B revealed:
*She denied that any staff had reported allegations of abuse or neglect against any other staff.
*When questioned specifically about any knowledge of incidents involving a staff member kicking residents or holding a cloth over a resident's mouth, she denied any knowledge of such incidents.

5. Confidential interview on 1/6/25 with anonymous staff member M revealed:
*Anonymous staff member M was initially afraid to come forward with the allegations against CNA J, due to CNA J's retaliatory nature.
*Anonymous staff member M was aware incidents of abuse were required to be reported immediately.
*Anonymous staff member M explained the reason why they did not report those incidents immediately was because previously when incidents were reported, CNA J's actions would improve for a short while, but then would return to the abusive behaviors.
*Anonymous staff member M confirmed that they and another staff member reported the above incidents to executive director (ED) A.
-Anonymous staff member M could not remember when they reported those incidents to ED A.

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6. Interview on 1/6/25 at 6:30 p.m. with ED A revealed:
*He denied that any staff had reported allegations of abuse or neglect against any other staff.
*However, when asked specific questions about CNA J allegedly having kicked a resident and having held a cloth over another resident's mouth, he confirmed he had been aware of those allegations.
-He explained that the staff member who brought forward those allegations was nondescript and could not describe specifically what CNA J had done.
*He confirmed the allegations were not reported to the required entities.

7. Continued interview on 1/6/25 at 6:35 p.m. with ED A and DON B about the allegations revealed:
*They confirmed they did not report those allegations to the required entities.
*They confirmed they were aware that allegations of abuse should have been reported to the SD DOH, law enforcement, and the Department of Human Services.

8. Interview on 1/6/25 at 7:04 p.m. with DON B revealed:
*She confirmed she learned about the allegations on 1/1/25 around 1:30 p.m. when registered nurse (RN) F contacted her.
-RN F told her that staff had come forward with concerns.
-RN F did not provide any details about the concerns, and DON B did not ask further questions about the concerns.
*She did not contact ED A about the allegations until the morning of 1/2/25.
*DON B confirmed that CNA J worked from 10:30

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p.m. on 1/1/25 to 7:30 a.m. on 1/2/25 after she learned of the allegations against the CNA.
-CNA J did not clock back in until 12:08 p.m. on 1/3/25 and worked until around 2:00 p.m.
*DON B explained that she had been the DON since July 2024. She was the Minimum Data Set (MDS) Assessment coordinator prior.
-She was not aware that the above allegations were the type that required reporting.
*She was not aware of the Administrative Rules of South Dakota detailing what type of incidents were required to have been reported.
*She was not aware of the provider's abuse and neglect prohibition policy on reporting and investigating allegations of abuse and neglect.
*She again confirmed the allegations of abuse were not reported to the required entities when they should have been.

9. Interview on 1/7/25 at 2:21 p.m. with DDCO C revealed:
*ED A was placed on suspension related to his failure to follow the provider's policy regarding abuse and neglect prevention and prohibition.
-He was supposed to have been acting as the abuse/neglect coordinator.
*She expected all allegations of abuse to have been taken seriously and reported to the required entities within the required timeframe.

10. Interview on 1/8/25 at 9:53 a.m. with DON B and DDCO C revealed:
*DDCO C explained that, to her understanding, the above incidents happened several weeks ago, and the witnesses came to ED A recently to report the incidents.
-It was her expectation that staff should have immediately reported the abuse.
-It was her expectation that all allegations should

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have been taken seriously, and the allegations should have been investigated thoroughly.

11. Refer to F600 finding 12 for additional details regarding when the anonymous staff members brought their concerns to ED A. It was confirmed that ED A learned about the allegations of abuse on 12/30/24 and had not reported or investigated the incidents.

12. Review of six employee training records, including CNA J, revealed each employee had received initial and/or annual training on the topics of abuse and neglect, resident rights, and mandatory reporting.

13. Review of the provider's March 2012 Director of Nursing Services (DNS) job description revealed:
*"Essential Functions
- ...6. Demonstrates an understanding and knowledge of certification laws and requirements, survey requirements, and Medicare program.
- ...8. Validates that reporting departments consistently meet state and federal requirements for long-term care facilities for licensure.
- ...10. Maintains open communication with ED regarding resident care activities, personnel or staffing problems, and other related topics.
- ...13. Understands the relationships with state and federal regulatory agencies, and works to maintain positive relationships."

14. Review of the provider's November 2019 Executive Director job description revealed:
*"Essential Functions
- ...4. Compliance Management
-- ...b. Grievance Official: Responsible for overseeing the grievance process.

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Responsibilities include: receiving and tracking grievances through to their conclusion, leading any necessary investigations, and complying with federal and state regulations and company policies as they apply to the grievance process.
-c. Abuse Coordinator: Oversee the implementation of policies and procedures necessary to prohibit and prevent abuse and neglect, including but not limited to: screening, training, prevention, identification, protection, and reporting/response. Coordinate abuse and neglect investigations.
--d. Compliance Liaison: Oversee the facility Compliance and Ethics Program. Coordinate employee, contractor, and volunteer compliance training to include the Code of Conduct, HIPAA [Health Insurance Portability and Accountability Act] policy, and other mandatory compliance policies."
*"Knowledge, Skills, and Abilities
-1. Familiarity with State Nursing Center rules and regulations, and applicable Federal and State laws."

15. Review of the provider's November 2019 Abuse, Neglect, or Exploitation policy revealed:
*"1. Complaints of abuse, neglect, or exploitation are viewed as very serious and are reported to your Regional Vice President and/or Regional Nurse Consultant immediately."
*" ...4. If abuse, neglect, or exploitation of a resident is suspected, act immediately to protect the resident from additional harm."
*" ...8. ...contact the appropriate State agency as soon as possible during the required reporting timeframe."
*"9. Notify the resident's family/significant other(s) of the suspected or alleged abuse."
*"10. Depending on the type of incident, it may

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also be appropriate to call the Long-Term Care Ombudsman, Adult Protective Services Offices, and/or the local police."
*" ...13. A staff member may notify the appropriate state agency of suspected/alleged abuse, neglect, or exploitation without fear of retribution. It is the responsibility of each employee to assure compliance with state abuse or suspected abuse reporting regulations."

16. Review of the provider's October 2022 Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation policy revealed:
*Definitions:
-"Mandatory Reporter: Anyone who is an employee, manager, agent, operator, owner, or contractor of a Medicare or Medicaid certified nursing facility..."
-"Immediately: Means as soon as possible, in the absence of a shorter State time frame requirement, but not later than 2 hours after the allegations is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. (Based on real clock time)"
*Procedure:
-" ...7. Reporting and Response: The Center immediately reports all suspected and/or allegations of abuse, neglect, and exploitation of residents, ...mistreatment, and injuries of unknown source in accordance with state and federal law."

17. Review of the provider's November 2016 Abuse Prohibition Notification policy revealed:

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F 609	Continued From page 40 *"Policy Statement: The Center complies with Federal and State requirements to screen, train, prevent, identify, investigate, protect, and report abuse, neglect, mistreatment, exploitation, and misappropriation of resident property." *" ...4. Alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, exploitation, and misappropriation of resident property, are reported immediately to the Executive Director (ED) and to other officials in accordance with Federal and State law. - ...The results of investigations are reported to the ED or his/her designated representative and to other officials in accordance with Federal and State law, not to exceed five working days of the incident."	F 609		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610	See next page	

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F 610	Continued From page 41 by: Based on South Dakota Department of Health (SD DOH) complaint intake review, interview, document review, and policy review, the provider failed to thoroughly investigate allegations of physical, mental, and verbal abuse by certified nursing assistant (CNA) J towards two of seven sampled residents (7 and 9). Findings include: 1. IMMEDIATE JEOPARDY NOTICE Notice of immediate jeopardy at F610 was given verbally and in writing via email on 1/8/25 at 3:57 p.m. to director of nursing (DON) B and division director of clinical operations (DDCO) C relating to failure to report allegations of abuse. A plan for removal of the immediacy was requested. On 1/8/25 at 4:30 p.m., DDCO C emailed a written plan for the removal of the immediate jeopardy. The removal plan was approved soon after 4:30 p.m. on 1/8/25. It was determined that the removal plan for F600 sent on 1/7/25 at 12:56 p.m. included action items to report the allegations of abuse to the required entities. "F610. The provider learned about concerns regarding the care and services a CNA was providing to residents on 1/1/25 at around 1:30 p.m. The provider failed to protect the residents from potential further abuse during the investigation by allowing the CNA to keep working an overnight shift from 10:30 p.m. on 1/1/25 to around 7:30 a.m. on 1/2/25. The provider failed to get more information from the reporting party to understand the extent of the situation. The provider failed to report the incidents to the necessary entities. The provider conducted an investigation into the allegations including	F 610	1. For residents 7 and 9 appropriate staff members were put on administrative leave. Residents were interviewed and felt safe in their environment or didn't recall. 2. Residents were interviewed to determine if abuse had occurred, issues identified were resolved. Residents unable to be interviewed had a physical exam completed by a LN to rule out abuse. No issues were identified. 3. The DDCO educated DNS on 1/6/2025 on the Abuse, Neglect or Exploitation Policy, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment of Resident Property, and Exploitation Policy, Abuse Prohibition Policy and Abuse Investigation Policy. The DNS or designee educated all staff on the Abuse, Neglect or Exploitation Policy, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment of Resident Property, and Exploitation Policy, and Abuse Prohibition Policy by 1/10/2025 or prior to their next working shift. 4. The DDCO or designee will reiew all facility investigations times two months to ensure they meet federal guidelines. (LP 2/5/2025) The ED/DNS or designee will interview four random residents' weekly times four weeks and monthly times two months to ensure residents have no concerns regarding their care, have any signs of abuse/neglect noted, and if they feel safe in their environment, if abuse/neglect is suspected allegation will be reported and thoroughly investigated. The ED/DNS or designee will bring the results of the audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	1/9/2025

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assessing the residents involved for injuries but nothing was documented.

The CNA has been suspended as of 1/6/2025 pending investigation. The initial report to DOH was submitted on 1/6/2025. All residents had a skin assessment completed and any residents with a BIMS [Brief Interview for Mental Status] above an eight have been interviewed regarding any potential for abuse by 11 am. A total of 49 residents were interviewed with no concerns, 1 resident with a concern that was reported to DOH this morning, residents with a BIMS below eight, the responsible party was contacted, seven with no concerns and five were left a voicemail. The reporting party has had a thorough investigation/interview with re-enactment completed by 10 am on 1/7/2025 by [ED A]. Abuse education provided by [DDCO C] to [ED A and DON B] as well as validating documentation in place to monitor skin or affected body parts for injury. Several staff from nursing, day shift 4, evening shift 2, night shift 1; dietary, one from days and one from evening; maintenance, activities, therapy and HR across all shifts have been interviewed regarding if they have ever seen another staff member abuse or neglect a resident in any way on 1/7/2025, no concerns noted.

Primary witness statements from other CNAs who witnessed the alleged perpetrator kick a resident in the shin twice, and a separate incident with a different resident where the alleged perpetrator put a washcloth over a resident's mouth to quiet the resident. Both those residents have dementia. Statements from staff indicate that this has been an ongoing issue and the alleged perpetrator improves their actions for a short while after being talked to by administration,

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but then slips back into their old ways. There is serious concern that the alleged perpetrator will potentially re-offend.

The CNA's making the allegation have been interviewed and a re-enactment of events has been conducted by [ED A]. The perpetrator was suspended 1/6/2025 pending investigation.

The two residents in [question] were assessed for physical harm, unable to assess for psychosocial harm due to cognition status. Both were placed on alert charting for 72 hours.

The [perpetrator] had a background check completed on 10/11/2023 with negative results for abuse.

The provider needs to take immediate action to prevent further potential abuse from occurring. The provider failed to report the incidents to the required entities, allowed the alleged perpetrator to work a shift following the report of alleged abuse, failed to conduct a thorough investigation, and failed to follow their abuse/neglect policy.

The event was reported 1/6/2025. [DDCO C], educated [ED A and DON B] on abuse policy, abuse reporting, suspension pending investigation and investigation by 1/6/2025 via phone.

All staff were re-educated on the facility abuse policy on 1/7/2025 and 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

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the last 30 days for possible abuse allegations on 1/7/2025.

An Ad hoc [meaning "when necessary or needed"] QAPI [quality assurance and performance improvement] is being completed 1/07/25 and the Medical Director was informed of the alleged deficient practice and current plan. Called at 10 AM by [DON B]."

The immediacy at F610 was determined to have been removed on 1/7/25 at 4:30 p.m. after onsite review. After removal of the immediacy, the severity and scope was a level G.

The census was 62.

2. Refer to F600 findings 2 and 3 for information about the SD DOH complaint intake forms.

3. Interview on 1/6/25 at 6:30 p.m. with executive director (ED) A revealed:
*He denied that any staff had reported allegations of abuse or neglect against any other staff.
*However, when asked specific questions about CNA J allegedly having kicked a resident and having held a cloth over another resident's mouth, he confirmed he had been aware of those allegations.
-He explained that the staff member who brought forward those allegations was nondescript and could not describe specifically was CNA J had done.
*The allegations were not investigated further.

4. Interview on 1/6/25 at 6:35 p.m. with DON B and ED A about their investigation process revealed:
*They both confirmed they were aware of the

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allegations detailed in F600 findings 2, 3, 6, and 12.
*As part of the investigation, DON B interviewed residents on different hallways to gauge if they had any concerns with the care they were receiving.
-She talked to three residents (2, 8, and 10). Those residents had lived at the facility "for a long time and are not afraid to speak their minds."
-They felt that 3 of 62 residents was an accurate sample.
-She did not document any of her interviews.
*She interviewed CNA J about the allegations. CNA J denied each allegation.
*Both DON B and ED A felt their investigation into the allegations was satisfactory.

5. Interview on 1/6/25 at 7:04 p.m. with DON B revealed:
*She confirmed she learned about the allegations on 1/1/25 around 1:30 p.m. when registered nurse (RN) F contacted her.
*She had not launched an investigation into the allegations until the next day and allowed CNA J to work an overnight shift.
*She was not aware of the provider's policy on investigating allegations of abuse.

6. Interview on 1/7/25 at 2:21 p.m. with divisional DDCO C revealed she expected all allegations of abuse to have been taken seriously and reported and investigated within the required timeframe.

7. Interview on 1/8/25 at 9:53 a.m. with DON B and DDCO C revealed:
*DDCO C explained that, to her understanding, the incidents between CNA J and residents 7 and 9 happened several weeks ago, and the witnesses came to ED A recently to report the

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incidents.
-It was her expectation that all allegations should have been taken seriously, and the allegations should have been investigated thoroughly.

8. Refer to F600 finding 12 for additional details regarding when the anonymous staff members brought their concerns to ED A. It was confirmed that ED A learned about the allegations of abuse on 12/30/24 and had not reported or investigated the incidents.

9. Review of the provider's March 2012 Director of Nursing Services (DNS) job description revealed:
*"Job summary: Is directly accountable to the Executive Director (ED) for the day-to-day operations, activities, and success of the resident care staff, as governed by the Center policies, and state and federal regulations ..."
*"Essential Functions
- ...2. Manages, supervises, and develops plans of action for assigned units, providing consistent monitoring and follow-through.
- ...6. Demonstrates an understanding and knowledge of certification laws and requirements, survey requirements, and Medicare program.
- ...8. Validates that reporting departments consistently meet state and federal requirements for long-term care facilities for licensure.
- ...10. Maintains open communication with ED regarding resident care activities, personnel or staffing problems, and other related topics."

10. Review of the provider's November 2019 Executive Director job description revealed:
*"Essential Functions
- ...2. Quality Management
-- ...d. Verify the Center meets state and federal

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F 610	Continued From page 47 requirements for long-term care Centers for licensure. -3. Human Resource Management -- ...e. Ultimately accountable for the adequate staffing of the Center. --f. Hire and manage within Federal and State laws, and Center policies and processes. -- ...j. Implement a management style that embodies the company's core mission, values, and culture, and holds department managers to the same standards. -4. Compliance Management -- ...b. Grievance Official: Responsible for overseeing the grievance process. Responsibilities include: receiving and tracking grievances through to their conclusion, leading any necessary investigations, and complying with federal and state regulations and company policies as they apply to the grievance process. -c. Abuse Coordinator: Oversee the implementation of policies and procedures necessary to prohibit and prevent abuse and neglect, including but not limited to: screening, training, prevention, identification, protection, and reporting/response. Coordinate abuse and neglect investigations. --d. Compliance Liaison: Oversee the facility Compliance and Ethics Program. Coordinate employee, contractor, and volunteer compliance training to include the Code of Conduct, HIPAA [Health Insurance Portability and Accountability Act] policy, and other mandatory compliance policies." *"Knowledge, Skills, and Abilities -1. Familiarity with State Nursing Center rules and regulations, and applicable Federal and State laws." 11. See F600 finding 20, 21, 22, and 23 for the	F 610		

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F 610	Continued From page 48 provider's policies on Abuse prohibition and investigation.	F 610		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint intake review, interview, document review, and policy review, the provider failed to ensure the facility was operated and administered by executive director (ED) A and director of nursing (DON) B in a manner that ensured the safety and overall well-being of all 62 residents in the facility. Those areas included: *Maintaining an effective abuse and neglect prohibition program that included following policies and procedures related to mandatory reporting and investigations of all allegations of abuse, relating to allegations of physical, verbal, and mental abuse by certified nursing assistant (CNA) J toward 2 of 7 sampled residents (7 and 9). *Maintaining 3 of 62 residents' (1, 3, and 6) right to personal privacy due to anonymous staff member M using their cellphone to secretly record private resident conversations. Findings include: 1. Record reviews, interviews, and policy reviews throughout the course of the survey, conducted from 1/6/25 through 1/8/25, revealed that ED A	F 835	1. For resident's 1, 3, 6, 7, and 9 employees were placed on administrative leave. All residents were interviewed and felt safe in their environment or couldn't recall. 2.Residents were interviewed to determine if abuse had occurred, issues identified were resolved. Residents unable to be interviewed had a physical exam completed by a LN to rule out abuse. No issues were identified. 3.The DDCO educated DNS on 1/6/2025 on the Abuse, Neglect or Exploitation Policy, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment of Resident Property, and Exploitation Policy, Abuse Prohibition Policy and Abuse Investigation Policy. The DDCO educated interim ED on policies listed above on 1/23/2025. 2.The regional team will meet with ED/DNS bi-weekly times one month to ensure they have the support they need and as needed after that. (LP 2/5/25) The Interim ED/DDCO or designee will interview four random residents' weekly times four weeks and monthly times two months to ensure residents have no concerns regarding their care, have any signs of abuse/neglect noted, and if they feel safe in their environment, if abuse/neglect is suspected allegation will be reported and thoroughly investigated. The Interim ED or designee will bring the results of the audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	1/23/2025

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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 system breakdown to ensure they had 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 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 about any concerns for abuse. Nothing about the

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investigation was documented.

Interview on 1/6/25 at 7:04 p.m. with DON B revealed that registered nurse (RN) F reported concerns about CNA J being rough with residents on 1/1/25 at around 1:30 p.m. DON B did not investigate the allegations further until the next day, and allowed CNA J to work an overnight shift from 1/1/25 to the morning of 1/2/25, which potentially put all residents at risk for further abuse by CNA J. She was not aware of the provider's abuse and neglect policy on suspending staff pending investigation.

Interview on 1/7/25 at 2:21 p.m. with divisional director of clinical operations (DDCO) C revealed that ED A was placed on suspension related to his failure to follow the provider's policy regarding abuse and neglect prevention, prohibition, reporting, and investigating. She confirmed that ED A was supposed to have been acting as the abuse coordinator. She confirmed that all allegations of abuse should have been taken seriously, reported to the required entities within the required timeframe, and investigated thoroughly. It was also discovered that ED A was aware of the secret recordings referenced above, as anonymous staff member M had emailed one of the recordings to ED A.

Interview on 1/8/25 with anonymous staff member N revealed that they reported their concerns for CNA J's abusive behaviors toward residents 7 and 9 to ED A on 12/30/24. ED A did not report or investigate those allegations.

Review of the provider's March 2012 Director of Nursing Services (DNS) job description revealed: *"Job summary: Is directly accountable to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING _____ B. WING _____	C 01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 51	F 835		

Executive Director (ED) for the day-to-day operations, activities, and success of the resident care staff, as governed by the Center policies, and state and federal regulations. Validates that the nursing department continues to develop and maintain high standards of excellence by being knowledgeable of industry changes and trends, and by implementing up-to-date nursing practices."
*"Essential Functions
-1. Develops and maintains a nursing service philosophy, objectives, standards of practice, policy and process manuals.
- ...6. Demonstrates an understanding and knowledge of certification laws and requirements, survey requirements, and Medicare program.
- ...8. Validates that reporting departments consistently meet state and federal requirements for long-term care facilities for licensure.
- ...10. Maintains open communication with ED regarding resident care activities, personnel or staffing problems, and other related topics.

Review of the provider's November 2019 Executive Director job description revealed:
*"Job summary: The Executive Director (ED) is directly accountable ...to provide strong overall leadership and management of a long-term care center. Manages delivery of the highest level of health services and quality of care that is responsive to customers' needs."
*"Essential Functions
- ...2. Quality Management
--a. Lead the process to develop and implement programs to maintain quality of care to meet established goals.
--b. Responsible to maintain a safe, healthy, clean, and well-organized building that reflects a high standard of care and service.

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F 835	Continued From page 52 -- ...d. Verify the Center meets state and federal requirements for long-term care Centers for licensure. -3. Human Resource Management -- ...e. Ultimately accountable for the adequate staffing of the Center. --f. Hire and manage within Federal and State laws, and Center policies and processes. --g. Facilitate communications from administrative level to staff and vice versa to promote optimum performance and understanding of goals. -- ...j. Implement a management style that embodies the company's core mission, values, and culture, and holds department managers to the same standards. -4. Compliance Management -- ...b. Grievance Official: Responsible for overseeing the grievance process. Responsibilities include: receiving and tracking grievances through to their conclusion, leading any necessary investigations, and complying with federal and state regulations and company policies as they apply to the grievance process. -c. Abuse Coordinator: Oversee the implementation of policies and procedures necessary to prohibit and prevent abuse and neglect, including but not limited to: screening, training, prevention, identification, protection, and reporting/response. Coordinate abuse and neglect investigations. --d. Compliance Liaison: Oversee the facility Compliance and Ethics Program. Coordinate employee, contractor, and volunteer compliance training to include the Code of Conduct, HIPAA [Health Insurance Portability and Accountability Act] policy, and other mandatory compliance policies." *"Knowledge, Skills, and Abilities	F 835		

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F 835	Continued From page 53 -1. Familiarity with State Nursing Center rules and regulations, and applicable Federal and State laws." Refer to F583, F600, F609, and F610.	F 835		