STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE , FLANDREAU, South Dakota, 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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/25/26 through 8/28/26. Riverview Healthcare Center was found not in compliance with the following requirements: F561, F583, F655, F684, F686, F692, F726, F732, F755, F759, F761, F804, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/25/26 through 8/28/26. Areas surveyed included allegations of potential resident abuse, an unexpected death, infection control practices, the environment related to the age and condition of the building, medication security related to a missing medication, nursing staff members' competencies, the quality of nursing care and rehabilitation treatment, and the quality and temperatures of the food served to residents. Riverview Healthcare Center was found not in compliance with the following requirements: F561, F610, F655, F684, F726, F755, F760, and F804.	F0000		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers	F0686	1. Resident 13's plan of care was reviewed by the Interdisciplinary team (IDT), necessary pressure ulcer prevention interventions were reviewed and put into place as needed. Care refusals have been reviewed, and physician notification has been completed. The care plan, resident tasks, and interventions were updated along with provider notification of new interventions and current weight and amount of weight loss since admission. All Residents that are at risk for pressure ulcers have the potential to not have the necessary pressure ulcer prevention interventions put into place, for refusals of care to not be accurately assessed and monitored, and for timely physician notification of decline. 2. The facility has implemented the following system changes: Nursing leadership will ensure residents at risk for pressure injuries receive individualized interventions based on assessment findings. Braden assessments will be completed upon admission, readmission, quarterly, significant change in condition, and as clinically indicated.	9/21/26

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0686 SS = G	Continued from page 1 from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to develop and implement pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) prevention interventions, accurately assess and monitor refusals, and follow physician's orders for one of one sampled resident (13) identified at risk for developing pressure ulcers, and dependent on the staff assistance with repositioning, who developed an unstageable pressure ulcer to her right heel and a Stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to her coccyx (tailbone). Findings include: 1. Observation and interview on 8/25/26 at 2:24 p.m. with resident 13 in her room revealed that she was in bed lying on her back, wearing a hospital gown. A blue foam heel support was on the floor at the end of her bed. Her face appeared thin, and her arms appeared to have reduced muscle mass. She said she was forgetful and was not out of bed yet because she had company. She did not know if she had an open area on her heel. 2. Observation and interview on 8/26/26 at 9:18 a.m. with resident 13 and contracted travel certified medication aide (CMA) EE in resident 13's room revealed resident 13 was in bed lying on her back wearing a hospital gown. A blue foam heel support was on the bed, but not under resident 13's heels. She was confused and asked, "What's going on here?" She became increasingly upset when she did not understand the surveyor's questions and the surveyor left the room. Contracted travel CMA EE remained in the room while the surveyor remained just outside the door. When contracted travel CMA EE exited resident 13's room, she stated that she did not know whether resident 13 had any pressure areas and that resident 13 was not repositioned while she was in the room because "she did not want anything." 3. Observation and interview on 8/26/26 at 3:05 p.m. with resident 13 and certified nursing assistant (CNA) Q revealed that resident 13 was in bed, lying on her back, wearing a hospital gown. A blue foam heel support was on the floor at the end of her bed.	F0686	Residents identified as at risk for pressure injuries will have individualized interventions implemented, which may include Turning and repositioning, Heel offloading devices, Pressure redistribution surfaces, Nutritional and hydration interventions, and Enhanced skin monitoring, Admission and readmission skin assessments will be completed for all residents and reviewed by nursing leadership to ensure timely identification of skin concerns. A wound tracking process (SNF IQ) has been implemented to ensure consistent documentation of wound location, measurements, staging, physician orders, treatment implementation, and weekly evaluations. Nursing leadership to review refusals of care related to repositioning, treatments, wound assessments, nutrition, hydration, and pressure-relieving devices. Repeated refusals will be reviewed by the interdisciplinary team with physician notification as appropriate. The DON/designee will educate licensed nurses, CNA's, and CMA's to include agency/contract staff on the residents that have potential for wounds or currently have wounds, where in PCC that this information can be found, what pressure ulcer prevention interventions are and where to find them in PCC. Licensed nurses have been educated on the Skin Integrity Policy and on how to complete the Nursing Admission eval and the importance of making note of all bruises, wounds, skin tears, edema, red blanchable areas, scabs and any other skin issue or concern on the body and the importance of checking all bony prominences during the initial skin assessment to be sure indications of possible pressure ulcers are identified and treatment interventions can be put in place at time of admit. Resident Care Managers (RCM) have been educated of the importance of following the Skin Integrity policy and reviewing all admission skin assessments and ensuring monitoring is documented in the chart per policy. Licensed nurses and RCM's have been educated in the importance of assessing and monitoring resident refusals of care and to ensure physician notification is completed when refusals of care, interventions, or preventative measures and are beginning to affect the health and wellbeing of the resident. All education was completed by 9/21/2026. Those not in attendance due to illness, vacation, and leave of casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. 3. Audits will be conducted on all new admissions/readmissions and 5 random residents that have skin integrity concerns or pressure ulcers to ensure: Completion of admission and readmission skin assessments have been completed and if skin issues/concerns have been identified they are put on the weekly monitoring system per the Skin Integrity Policy, completion of Braden risk assessments, presence of individualized pressure injury prevention interventions for at-risk residents, documentation of turning and	

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F0686 SS = G	Continued from page 2 Resident 13 was confused, stating that she needed to get home to get ready for a wedding and she had agreed to stay at this place for just one night. 4. Interview on 8/26/26 at 3:07 p.m. with CNA Q revealed that she worked primarily on the first floor, that resident 13 had moved to the first floor about one week ago, and that resident 13 was out of bed and dressed two times that week on the days that CNA QQ had worked. She felt that resident 13 was difficult to care for because resident 13 was confused and angry, yelled frequently, and refused to allow CNA Q to help her. She thought that resident 13 had "sores on her bottom and her feet," but was not sure. CNA Q said that resident 13 "sometimes" allowed her to reposition her. 5. Observations on 8/27/26 from 8:35 a.m. to 2:05 p.m. revealed that resident 13 was in bed positioned on her left side. The blue foam heel support was on the floor at the end of her bed. 6. Interview on 8/27/26 at 2:05 p.m. with CNA U revealed that she was in resident 13's room four times that day to attempt to assist resident 13 to get dressed and out of bed. Resident 13 had refused her breakfast and her lunch; she was not bathed or dressed, said she was having pain, and did not want to be repositioned. CNA U stated that she told CMA V that resident 13 had refused her assistance and that she was in pain. She thought CMA V had reported resident 13's refusal to get dressed, eat, or to get out of bed to contracted travel licensed practical nurse (LPN) R. 7. Interview on 8/27/26 at 2:13 p.m. with contracted travel LPN R revealed that he was the nurse caring for resident 13 that day. No one reported to him that resident 13 had refused to get out of bed, be repositioned, was having pain, and did not eat her breakfast or lunch that day. He was aware that she frequently refused care and her meals. Resident 13 had refused to allow him to complete her heel dressing change that day. He stated that resident 13's physician was aware that resident 13 refused meals and personal care, and that the physician had recommended that the staff "keep monitoring resident 13." 8. Review of resident 13's electronic medical record (EMR) revealed that she admitted to the facility on	F0686	repositioning,offloading of heel interventions, documentation and follow-up of resident refusals, compliance with physician-ordered wound treatments, weekly wound assessment documentation, Weight loss and nutritional risk review for residents with wounds or pressure injury risk have been completed timely and implemented 5 Random residents with identified skin integrity issues or concerns will be observed to ensure that Pressure ulcer prevention measures are in place and that the current and appropriate dressing is in place. The DON or designee will complete the audits and observations weekly for 4 weeks, bi-monthly for 2 months and monthly for 4 months. Audit results will be compiled by the Director of Nursing and presented monthly for three months to the Quality Assurance and Performance Improvement (QAPI) Committee, which includes the Administrator, Director of Nursing, Medical Director, and department managers. 4. 9/21/2026	

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F0686 SS = G	Continued from page 3 6/10/26. Her diagnoses included Type 2 Diabetes Mellitus, (a condition involving disruptions in how the body regulates blood sugar), hypomagnesemia (an electrolyte disorder defined by a low blood serum magnesium level), hypokalemia (a medical condition where the level of potassium in your blood drops below the normal range), sepsis (a life-threatening medical emergency that happens when the body has an extreme, harmful response to an infection), anxiety, and fractures of her sacrum (tailbone) and left femur (leg). Her 8/11/26 Brief Interview for Mental Status (BIMS) assessment score was 6, which indicated her cognition was severely impaired. Resident 13's 6/10/26, 6/17/26, and 6/24/26 Braden Scale for Predicting Pressure Sore Risk (a tool used to assess the risk of developing pressure ulcers) scores indicated that resident 13 was "AT RISK" for developing a pressure ulcer. Her 7/2/26 Braden Scale score indicated that she was at "MODERATE RISK" for developing a pressure ulcer. A 6/10/26 Admission Skin/Wound Evaluation revealed that resident 13 admitted to the facility with a right calf (back of lower leg) non-pressure injury and a left hip surgical incision. A 6/16/26 Weekly Wound Evaluation indicated she had a right calf non-pressure injury and that her left hip surgical incision was "improving." There was no documentation that the left hip incision was assessed after 6/16/26 or when that incision was healed. The right calf non-pressure injury area was marked healed on 7/14/26. Resident 13's 6/16/26 Minimum Data Set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan (personalized plan that addresses a resident's care needs, goals, and interventions) to manage the resident's care needs) indicated resident 13 was at risk for pressure injuries, had a skin tear, and a surgical wound but did not have any unhealed pressure ulcers. Resident 13 had a pressure-reducing mattress, but no pressure-reducing device for the wheelchair, no turning and repositioning program, and no nutrition or hydration intervention was in place to manage skin problems. Resident 13 required maximum staff assistance with dressing, bathing, and toileting, and moderate staff assistance with transfers and bed	F0686		

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F0686 SS = G	Continued from page 4 mobility. Resident 13 was hospitalized after a fall on 6/21/26 and readmitted to the facility on 6/24/26 with a sacral fracture. A 6/24/26 Admission Skin/Wound Evaluation indicated that resident 13 was readmitted to the facility with a right calf non-pressure injury and a pink blanchable (skin or a red mark that turns white or pale when you press on it and returns to its normal color when you release the pressure) non-pressure injury area to her coccyx. There was no documented response to the question "Does the Resident present with a new Skin Impairment? (If yes, proceed to Weekly Wound Evaluation) on her 6/24/26 Readmission Nursing Evaluation. A 6/25/26 [name of wound care provider redacted] wound assessment indicated that resident 13 admitted to the facility with a surgical incision to her left hip and a "Non pressure injury [that was] superficial" to her right lower calf. The primary diagnosis was "Stage 2 [II] pressure ulcer to the right lower leg/shin." Resident 13's 6/30/26 significant change MDS assessment indicated resident 13 was at risk for pressure injuries, had a skin tear, and a surgical wound but did not have any unhealed pressure ulcers. Resident 13 had a pressure-reducing mattress and a pressure-reducing device for the wheelchair. No turning and repositioning program was in place, and no nutrition or hydration intervention was in place to manage skin problems. Resident 13 required maximum staff assistance with dressing and bathing and was dependent on staff for toileting, transfers, and bed mobility. A 7/2/26 Weekly Wound Evaluation indicated that she had a left buttocks non-pressure injury "skin tear" that was 4.5 centimeters (cm) long by 4 cm wide and an 11.4 cm by 4 cm non-pressure maceration (the softening, whitening, and breakdown of skin caused by prolonged exposure to moisture)/shearing and slit to her coccyx. The skin tear to her left buttocks was documented as healed on 7/7/26.	F0686		

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F0686 SS = G	Continued from page 5 A 7/7/26 Weekly Wound Evaluation indicated that she had a 2.5 cm long by 0.5 cm wide Stage II pressure ulcer to her coccyx that was 0.2 cm in depth and that the pressure ulcer was "present on admission." A 7/7/26 [name of wound care provider redacted] wound assessment identified that resident 13 had a Stage II coccyx wound, that the age of the wound was "unknown. Returned from [a] hospital stay on 6/24/26 -- [The wound was] Noted by nursing on 7/2/26," that measured 3.0 cm long by 0.5 cm wide and 0.2 cm deep. The primary diagnosis was "Stage 2 pressure ulcer to the right lower leg/shin." And "Stage 2 pressure ulcer on the coccyx (tailbone)." The treatment goal included "to achieve wound closure through TIME principals [principles that provide a clinical framework for chronic wound bed preparation, standing for Tissue, Infection/Inflammation, Moisture, and Edge of wound healing, adequate offloading and [to] prevent recurrence]." A 7/8/26 Weekly Wound Evaluation indicated that she had a 2.5 cm long by 3.5 cm wide suspected deep tissue injury pressure ulcer to her right heel and that the pressure ulcer was "present on admission." A 7/14/26 Weekly Wound Evaluation identified the wound site as "Heel Right" and had a "Description Heel Left," which indicated that the wound was "improving," and that the wound was not present on admission. The Stage II coccyx pressure ulcer marked "present on admission" was documented as healed. A 7/14/26 [name of wound care provider redacted] wound assessment indicated that resident 13's right lower calf and coccyx wounds were "HEALED," and identified "a pressure injury unstageable -fluid filled blister" to her right heel that measured 2.5 cm in length by 3.0 cm wide. The treatment goal included resident 13 sleeping on a pressure-reducing mattress and using a pressure-reducing cushion in her wheelchair. Resident 13's 7/17/26 End of PPS (Perspective Payment System) Part A stay MDS assessment indicated resident 13 was at risk for pressure injuries and had one unstageable pressure injury that was	F0686		

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F0686 SS = G	Continued from page 6 not present on admission, refused to get dressed, and required maximum staff assistance with bathing and bed mobility. A 7/21/26 [name of wound care provider redacted] wound assessment indicated that resident 13's unstageable pressure ulcer to her right heel measured 3.0 cm long by 3.5 cm wide, and recommended repositioning every two hours to "minimize shearing." A 7/22/26 Weekly Wound Evaluation identified the wound site as "Heel left" and a "Description Heel Left" that indicated that the pressure ulcer was unstageable, was not present on admission, measured 3.0 cm long by 3.5 cm wide, and was being monitored by the staff. A 7/28/26 Weekly Wound Evaluation identified the wound site as "Heel Right" and a "Description Heel Right" that indicated that the pressure ulcer was unstageable, was not present on admission, measured 3.0 cm long by 3.0 cm wide, and was improving. A 7/28/26 [name of wound care provider redacted] wound assessment indicated that resident 13's unstageable pressure ulcer to her right heel measured 3.0 cm long by 3.5 cm wide, identified a "New coccyx slit opening" that was "moisture associated," with a primary diagnosis of "Stage 2 pressure ulcer on the coccyx," and recommended "repositioning every 2 hours- side by [to] side." Resident 13 had a 7/29/26 physician's order to "Clean skin tear to coccyx with wound cleanser and apply Zinc Oxide [a topical skin protectant that creates a barrier over the skin] to the area with each brief change. Do not scrub zinc oxide off. Contact provider if wound does not improve." An 8/6/26 Weekly Wound Evaluation identified the wound site as "Heel Right" and a "Description Heel Right" that indicated that the pressure ulcer was unstageable, was not present on admission, measured 2.0 cm long by 2.0 cm wide, and was improving. Resident 13 was admitted to the hospital on 8/6/26	F0686		

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F0686 SS = G	Continued from page 7 and readmitted to the facility on 8/11/26. There was no documentation that an Admission Skin/Wound Evaluation was completed for resident 13 when she readmitted to the facility on 8/11/26. An 8/13/26 Weekly Wound Evaluation identified the wound site as "Foot Right" and a "Description Foot Right," indicated that the pressure ulcer was unstageable, was not present on admission, measured 2.0 cm long by 2.0 cm wide, and was improving. Resident 13's 8/13/26 significant change MDS assessment indicated that resident 13 was at risk for pressure injuries, had one unstageable pressure injury that was not present on admission, and had a pressure-reducing mattress and a pressure-reducing device for her wheelchair. She was not on a turning and repositioning program, and there was no nutrition or hydration intervention in place to manage skin problems. An 8/18/26 Readmission Nursing Evaluation indicated that resident 13 did not have a "new Skin Impairment." An 8/18/26 [name of wound care provider redacted] wound assessment indicated that resident 13 refused to allow the wound care provider to view the "New coccyx slit opening" that was identified on 7/28/26. Resident 13's unstageable pressure ulcer to her right heel, identified on 7/14/26, was open, "Stage 2," and measured 2.5 cm long by 3.5 cm wide. This document referred to both "left heel" and "right heel" without identifying a new area of concern. An 8/20/26 Weekly Wound Evaluation indicated that resident 13 had a "First Observation" of a non-pressure injury wound on her coccyx that was not present on admission that measured 1.5 cm long x 0.0 cm wide. There was no documentation that a Weekly Wound Evaluation was completed on resident 13's right heel, foot, or left heel after 8/13/26. Resident 13's 6/10/26 through 8/26/26 weight documentation indicated that she had lost 29.1 pounds. On 6/10/26, she weighed 139.0 pounds. On 6/11/26, she weighed 132.7 pounds. On 6/28/26, she weighed 128.3 pounds. On 8/1/26, she weighed	F0686		

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F0686 SS = G	Continued from page 8 125 pounds. On 8/21/26, she weighed 115.2 pounds. On 8/26/26, she weighed 109.9 pounds. On 8/27/26, resident 13's physician was notified of her 29.1-pound weight loss. 9. Interview and review of resident 13's Weekly Wound Evaluation and [name of wound care provider redacted] wound assessment documentation on 8/27/26 at 4:23 p.m. with director of nursing (DON) B and registered nurse (RN)/regional director C revealed there were several changes in who was responsible for overseeing wound care in the last few months. The most recent wound care nurse, previous RN/wound nurse FF no longer worked at the facility as of 8/25/26 and was unavailable for an interview. RN/regional director C was the "acting DON" from 7/8/26 until DON B started in that role at the facility on 7/27/26. DON B assumed the position of wound nurse, in addition to her position as DON, on 8/25/26, and was still learning about the residents. They did not know the location of resident 13's pressure ulcers and confirmed inconsistencies in the documentation regarding the ulcers staging, locations, and times of identification. 10. Observation and interview on 8/27/26 at 4:35 p.m. with DON B, RN/regional director C, and resident 13 in resident 13's room revealed that resident 13 was in bed. DON B and RN/regional director C confirmed resident 13 had a foam dressing on her right heel; there was no other wound or dressing on resident 13's right foot. There was no wound or wound dressing observed on resident 13's left heel. Resident 13 refused to allow DON B and RN/regional director C to assess her coccyx area at that time. DON B and RN/regional director C completed a dressing change to resident 13's right heel pressure ulcer and reported that the wound appeared to be healing. 11. Continued interview and review of resident 13's EMR on 8/27/26 at 4:50 p.m. with DON B and RN/regional director C revealed that resident 13 had a 7/28/26 physician's order for "Cleanse right heel with wound cleanser, apply betadine solution, cover with telfa [a sterile, non-adherent wound dressing designed not to stick to healing tissue], cover with kerlix [gauze bandage rolls] and secure with medipore tape [a breathable, soft cloth medical tape used to secure wound dressings]. Change every 3 days." That dressing was not the dressing on resident 13's right heel on 8/27/26 at 4:35 p.m.	F0686		

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F0686 SS = G	Continued from page 9 when DON B and RN/regional director C completed the physician's ordered dressing change. RN/regional director C expected the physician's ordered dressing to be on resident 13's right heel, and that the nurse who completed the dressing change would have documented why there was a different dressing used. She was unable to locate any documentation of why the physician's order was not followed. Review of resident 13's Treatment Administration Record (TAR) revealed that dressing changes were documented as completed daily from 8/1/26 through 8/5/26, on 8/12/26, 8/13/26, 8/15/26, daily from 8/17/26 through 8/19/26, and daily from 8/21/26 through 8/25/26. Resident 13 was hospitalized from 8/7/26 to 8/11/26. RN/regional director C confirmed that the physician's order to change the wound dressing every three days was not followed, and that this could have impacted the healing process. RN/regional director C confirmed that there was no dressing or observed wound on resident 13's left heel or foot. RN/regional director C stated that if the wound care provider's 8/18/26 documentation revealed resident 13 had a primary diagnoses of "Stage 2 pressure ulcer of the left heel," "Stage 2 pressure ulcer to the right lower leg/shin," and "Stage 2 pressure ulcer on the coccyx (tailbone)," that she thought the reference to resident 13's left heel in the documentation was an error and that the document should have stated "right heel." RN/regional director C stated that on 7/6/26, resident 13's pressure ulcer interventions included a pressure-relieving mattress on her bed and a cushion in her wheelchair, daily inspections of her skin during care, and to "administer treatments as ordered." She confirmed that resident 13 was at risk for developing pressure wounds and that she did not have adequate interventions in place to prevent her coccyx and right heel pressure ulcers from developing. RN/regional director C expected that interventions, including heel boots, elevating the heels off the mattress, and turning and repositioning, would have been included in resident 13's care plan when she admitted to the facility to reduce her risk of developing pressure ulcers. RN/regional director C stated that if resident 13 refused those interventions, her refusal should have been documented. She confirmed that there were a "limited number" of documented days when resident 13 "refused care."	F0686		

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F0686 SS = G	Continued from page 10 Resident 13's "pressure injury on right foot," which was identified on 7/14/26, was added to the care plan on 7/21/26 with the intervention "I have a heel elevator device in my room to help prevent pressure injury on [my] heels. I refuse to use it at times. Please encourage it's [its] use and position it appropriately." DON B expected the CNAs to report resident 13's refusals of care, including eating and repositioning when they occurred, to the nurse in charge of resident 13's care so that they could be documented. The nurse was to notify the resident's physician if needed, and alternative interventions should be attempted. RN/regional director C confirmed that the facility had an "all-inclusive" skin care policy and that there were no specific policies related to pressure ulcer prevention or wound care. 12. Interview on 8/28/26 at 9:20 a.m. with CNA W revealed that she used the resident's care plan to guide her care of the residents; she worked full-time and felt she knew most of the residents pretty well. She was unsure if there was information in resident 13's care plan related to her pressure ulcers, but stated that there were many contracted travel staff members who worked at the facility. She thought that information would be good to have in the resident's care plan since resident 13 often refused her meals and staff assistance with personal care. 13. Review of the provider's March 2025 CNA Job Description revealed the CNAs performed duties in caring for residents "consistent with the plan of care and established long-term care standards..." Essential functions included "Turns and repositions bedfast residents, alone or with assistance, and utilizing proper body mechanics, to prevent pressure ulcers." The CNAs report "to the Licensed Nurse directing and overseeing resident care on assigned unit." 14. Review of the provider's April 2022 Wound Care Certified Specialist Job Description revealed that the Wound Care Certified Specialist was " Responsible for planning, coordinating, and documenting wound care... in conjunction with the center's clinical team,	F0686		

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F0686 SS = G	Continued from page 11 develops and implements a wound care plan that meets each patient's specific needs and reflects best practice.. acts as a consultant and educator to other staff regarding wound/skin care patients and practices." " Performs ongoing, accurate and comprehensive wound/skin care assessments of each assigned patient…obtains physician's orders…develops and implements an evidence-based plan of care for each wound care patient…provides clear, concise documentation…provides supervision and mentorship related to wound care for skilled nursing, aides, and therapy staff…" 15. Review of the provider's updated March 2026 Skin Integrity policy revealed "It is the policy of this center that a resident who enters the center without pressure ulcers/injury does not develop pressure ulcers/injury unless the individual's clinical condition demonstrates that they were unavoidable and a resident having pressure ulcers/injury receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing." "Upon admission, the licensed nurse (LN) establishes a plan of care based on risk factors or presence of wounds."	F0686		
F0692 SS = G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F0692	1. Resident 13's nutritional and weight loss status have been reviewed and necessary changes have been made to the orders to include notification to the provider of interventions and current weight loss. All residents with potential or indication of weight loss have been reviewed to ensure they have the proper interventions to aid in the prevention of significant weight loss and the physician has been notified of the interventions and weight loss findings. 2. Weights will be obtained per the provider order for residents needing weight monitoring. If a resident has conflicting weights or missing weights a weight will be obtained immediately upon finding inaccurate or missing information and recorded in Point Click Care (PCC). If a weigh is grossly incorrect it will be struck out by nursing and a re-weigh will obtained. Weekly meeting of weights and wounds is conducted every Friday to include DON, Nurse managers, dietary manager, and registered dietician (RD). This meeting is held to review resident weights and identify those residents that may be experiencing weight loss or weight gain, requiring nursing or dietary interventions to aid in the prevention of significant weight loss. During this meeting weights are reviewed and discussed, dietary and nursing interventions are reviewed, updated, changed to reflect current resident requirements to sustain or maintain weight. Prior to the close of this meeting the DON will complete a fax form to update the physician on new or updated interventions	9/21/26

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F0692 SS = G	Continued from page 12 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to identify and implement interventions promptly to aid in the prevention of significant weight loss and failed to notify the resident's physician of the significant weight loss for one of one sampled resident (13), who lost 29.1 pounds within two months. Findings include: 1. Observation and interview on 8/25/26 at 2:24 p.m. with resident 13 in her room revealed she was in bed wearing a hospital gown. Her face appeared thin, and her arms appeared to have reduced muscle mass. She asked the surveyor if it was lunchtime, indicated she was unsure whether she had eaten anything that day because she was forgetful, stated she was not hungry, and that she would ask for a snack if she became hungry. 2. Review of resident 13's electronic medical record (EMR) revealed that she admitted to the facility on 6/10/26. Her diagnoses included Type 2 Diabetes Mellitus, (a condition involving disruptions in how the body regulates blood sugar), hypomagnesemia (an electrolyte disorder defined by a low blood serum magnesium level), hypokalemia (a medical condition where the level of potassium in your blood drops below the normal range), sepsis (a life-threatening medical emergency that happens when the body has an extreme, harmful response to an infection), anxiety, and fractures of her sacrum (tailbone) and left femur (leg). Her 8/11/26 Brief Interview for Mental Status (BIMS) assessment score was 6, which indicated her cognition was severely impaired. A 6/10/26 physician's order for "Monthly Weights & [and] Vital Signs [measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate]." A 6/11/26 physician's order for "Daily weight. Once a day. Notify MD [medical doctor] of wt [weight] change equal to or > [greater than] 3 lbs [pounds] in 2 days or = [equal to] or >5 lbs in a week. Check to see what previous weights have been," with an end date of 6/14/26. A 6/26/26 physician's order for "daily weight x 3 [for three] days" was marked complete. A 7/1/26 physician's order for "Monthly Weights..." was discontinued on 8/3/26. An 8/3/26 physician's	F0692	that will aid in the prevention of significant weight loss and will indicate the current and previous weight of the resident. A fax will be sent for each resident needing updates or changes in their interventions or weights. Nursing staff (licensed nurses (RN or LPN), certified medication aids (CMA) and certified nursing assistants (CNA) have been educated by the DON regarding weights, weight policy, and importance of knowing previous weight and current weight, need for accurate weights, and when a resident will need to be re-weighed by 9/21/2026. All staff have been educated in the importance of not striking out weights and that only nursing or the RD can strike out a weight. Residents that have been identified by the RD as having weight loss will be monitored weekly. New and existing resident weights will be monitored per provider order and reviewed for accuracy and any missed weights. If a weight signifies a weight loss consistently of 5 lbs or more in one month, this resident will be added to the Weekly Weight and Wound meeting to be monitored by the IDT team. 3. The RD, DON or designee will monitor new admissions and readmission weights and 10 random resident weights that have diagnosis that have the potential to cause significant weight loss or current conditions support food intake of 50% or less. Audits will be conducted weekly for 8 weeks and then bi-monthly for 1 month, monthly for 3 months. The QAPI Committee will review audit findings, identify trends, evaluate the effectiveness of corrective actions, and implement additional corrective measures and staff education as needed to maintain compliance. 4. 9/21/2026	

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F0692 SS = G	Continued from page 13 order for "Monthly Weights…" was discontinued on 8/5/26. On 6/10/26, resident 13 weighed 139.0 pounds. On 6/11/26, she weighed 132.7 pounds. There was no documentation that resident 13 was weighed on 6/12/26 or 6/13/26 as ordered or that her physician was notified of her 6.3-pound weight loss. There was no documentation that resident 13 was weighed weekly between 6/11/26 and 6/28/26, or that resident 13 was weighed on 6/26/26 or 6/27/26 as ordered. On 6/28/26, she weighed 128.3 pounds. There was no documentation that resident 13's physician was notified of her 10.7-pound weight loss. On 8/1/26, resident 13 weighed 125 pounds. There was no documentation that resident 13's physician was notified of her 14-pound weight loss since her admission to the facility. On 8/21/26, resident 13 weighed 115.2 pounds. There was no documentation that resident 13's physician was notified of her 23.8-pound weight loss since admission to the facility. On 8/26/26, resident 13 weighed 109.9 pounds. She had lost 29.1 pounds. A 6/16/26 Nutrition Evaluation Form indicated that resident 13 weighed 139.0 pounds (her 6/10/26 most current documented weight), had a non-pressure injury to her right lower leg, a surgical wound on her left hip, was at risk for skin breakdown, preferred to eat in her room, and ate between 25-75% (percent) of her meals. Registered dietitian (RD) J recommended Pro Heal supplements daily "to aid in wound healing," that her weights were stable, and indicated that those supplements could be discontinued if resident 13 refused them or her meal intakes improved. A 6/30/26 Nutrition Evaluation Form indicated that resident 13 readmitted to the facility from the hospital (on 6/24/26) after a fall, weighed 128.3 pounds, had a 7.7% weight loss in the past 30 days, and that there was "no edema (swelling) noted at this time nor at admission." RD J recommended discontinuing the Pro HEAL supplements and starting Calorie Dense Medication Pass supplements for "more calories [and] to encourage stable weights." An 8/3/26 Nutrition Evaluation Form indicated that resident 13 acquired a right unstageable heel pressure ulcer that measured 3.0 cm (centimeters) by 3.0 cm and a left unstageable heel ulcer that	F0692		

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F0692 SS = G	Continued from page 14 measured 3.0 cm by 3.5 cm. weighed 125.0 pounds, had a 5% weight loss in 30 days, and a 7.5% weight loss in the past 90 days. Resident 13 was independent with eating her meals in her room, and RD J recommended restarting the Pro HEAL supplements, continuing the Calorie Dense Medication Pass supplements, and to "encourage PO (oral) intake at meals." An 8/13/26 Nutrition Evaluation Form indicated that resident 13 readmitted to the facility from the hospital on 8/12/26 related to a urinary tract infection and sepsis. She weighed 125.0 pounds (her 8/1/26 documented weight). Resident 13 was independent with eating her meals in her room, had "multiple" [meal] refusals over the past 14 days, had a pressure ulcer on her right heel, and RD J recommended increasing the Calorie Dense Medication Pass supplement and that she would "continue to monitor for a new weight and monitor PO intakes." An 8/25/26 Nutrition Evaluation Form indicated that resident 13 weighed 115.2 pounds, had a 7.5% weight loss in the past 90 days, and that her "weight loss [was] r/t [related to] sepsis while hospitalized, PO intakes are baseline for resident before hospitalization." Resident 13 had pressure ulcers on her right foot and heel, and acquired a non-pressure injury on her coccyx (tailbone) on 8/20/26. RD J requested another weight and indicated, "RD [J] recommends keeping current interventions in place to give them time to be effective. Resident 13's care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated that on 7/8/26, the "Nutrition Hydration" focus area was updated to include her risk of losing weight. Interventions included that resident 13 was on a regular diet, she was independent at meals, her dining preferences would be honored, she took "Pro HEAL Liquid Protein one time a day," she did not have religious, ethnic, or cultural food preferences, and that the staff members were to observe for signs and symptoms of dehydration. There was no documentation of resident 13's repeated meal refusals, significant weight losses, changes to RD J's recommendations for meal supplements, or when to notify her physician. Resident 13's Nutrition-Meal Monitor documentation	F0692		

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F0692 SS = G	Continued from page 15 indicated that from 8/2/26 through 8/27/26, resident 13 was offered three meals a day on twelve days, two meals a day on six days, and one meal a day on two days. Resident 13 was hospitalized from 8/6/26 through 8/11/26. Resident 13 refused 12 of 50 meals offered between 8/2/26 and 8/27/26. There was no documentation that the staff consistently reported those refusals, and there were no documented care plan interventions addressing her frequent meal refusals. 3. Interview on 8/25/26 at 10:51 a.m. with RD J revealed that she was aware resident 13 had lost 29.1 pounds since her admission to the facility. She thought the weight loss was due to resident 13 being in the hospital recently. She requested the staff to obtain "another weight" after her 8/25/26 assessment but thought resident 13 had refused to be reweighed. She expected the nursing staff members to obtain a resident's weight and reweigh that resident on the same day or the next day if there was more than a five-pound weight change since the last weight. She confirmed that resident 13 was not reweighed whenever there was a weight loss of more than 5 pounds. RD J stated that the "nurse in charge" of resident 13's care was responsible for notifying the physician of any weight loss for additional recommendations and interventions. RD J recommended adding supplements because resident 13 was losing weight. RD J stated resident 13 had reported that her appetite was great and that she liked the meal supplements. The documentation RD J had reviewed supported that resident 13 was eating well and was offered additional food if she slept through a meal. She thought that resident 13's weight would "bounce back" after she returned from the hospital. 4. Interview on 8/26/26 at 3:06 p.m. with certified nursing assistant (CNA) Q revealed that resident 13 was independent with eating and did not need to be fed. She had refused her breakfast and lunch trays to be left in her room that day (8/26/26) and did not eat those meals. CNA Q did not report resident 13's breakfast and lunch refusals to the nurse because she thought the nurses knew resident 13 was refusing to eat her meals, and she refused to get out of bed. She thought that resident 13 ate better in the evening. 5. Interview on 8/27/26 at 2:05 p.m. with CNA U revealed that she thought that resident 13 was alert	F0692		

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F0692 SS = G	Continued from page 16 and oriented and made the choice to eat all her meals in her room. Resident 13 had refused to eat her breakfast and lunch that day (8/27/26). CNA U did not report to anyone that resident 13 refused her breakfast and lunch that day because she thought that certified medication aide (CMA) V had reported it to contracted travel licensed practical nurse (LPN) R. 6. Interview on 8/27/26 at 2:13 p.m. with contracted travel LPN R revealed that he was the nurse caring for resident 13 that day. No one reported to him that resident 13 did not eat her breakfast or lunch that day, but he was aware that she refused her meals frequently and had experienced some weight loss since her admission to the facility. He was unsure how much weight resident 13 had lost, but he would receive an alert in the EMR when a resident with weight loss needed to be reviewed. He stated that resident 13's physician was aware of her weight loss, that resident 13 refused meals and personal care, and that the physician had recommended that the staff to "keep monitoring" resident 13. 7. On 8/28/26 at 8:00 a.m., a request was made to registered nurse (RN)/ regional director C for all notifications sent to resident 13's provider regarding her weight loss since her admission to the facility and interventions added or attempted. 8. Interview on 8/28/26 at 9:20 a.m. with CNA W revealed that she used the resident's care plan to know how to care for the residents; she worked full time and felt like she knew most of the residents well. She was unsure if there was information in resident 13's care plan related to her weight loss but stated that there were many contracted travel staff members who worked at the facility. She thought that information would be good to have in the resident's care plan since resident 13 often refused her meals and staff assistance with personal care. 9. Interview and review of resident 13's weight documentation and physician notifications on 8/28/26 at 11:18 a.m. with director of nursing (DON) B and RN/regional director C revealed that resident 13 was last weighed on 8/26/26 and weighed 109.9 pounds. Resident 13 had lost 29.1 pounds between 6/10/26 and 8/26/26. She thought that RD J was aware of resident 13's weight loss and recommended supplements because resident 13 was not eating well.	F0692		

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F0692 SS = G	Continued from page 17 RN/regional director C expected resident 13 to be weighed "following the physician's orders," to be reweighed when she had a weight loss of five pounds or more in a week, and her physician to be notified of the weight loss. She confirmed that resident 13 was not weighed according to the physician's orders, nor was she reweighed on the same day she had lost five or more pounds in a week. Resident 13's physician was notified on 8/27/26 of her 29.1-pound weight loss, but RN/regional director C did not hear back from the physician at that time. There was no other documentation indicating that resident 13's physician was notified of weight losses greater than 5 pounds per week, which could have resulted in a lack of timely medical evaluation and contributed to continued significant weight loss. 10. Review of the provider's May 2026 Weights policy revealed that "The Center uses weights as one component of data collection to evaluate the resident's nutritional status." Newly admitted residents were weighed "on admission, then weekly for 4 weeks. If weights and nutritional status are stable after 4 weeks, weigh the resident once per month." Re-weigh criteria included "any weight with [a] 5-lb [pound] variance is re-weighed. After a re-weigh has been completed, that weight is recorded in PCC [Point Click Care, the provider's EMR] on the same day [it was] taken. If a significant variance is verified after the re-weigh, the nurse: Documents the weight variance in the medical record. Revises the care plan, as appropriate. Refers to the RD for evaluation, as indicated. Notifies the medical provider and resident/resident representative."	F0692		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by:	F0684	1. Resident 20 has had no further issues or concerns with receiving or application of the Butrans Patch. All other residents who are prescribed a Butrans Patch are at risk for having issues of receiving, proper securing or timely application of the patch. 2. Butran patches will come from pharmacy, two nurses will sign on manifest that it has arrived and will immediately take to the medication cart, sign in medication using PharMerica book and put in narcotic lock box. It will remain in the cart and counted at every shift change with 2 nursing staff (nurse/nurse or nurse/CMA, CMA/CMA) until it is time to be applied. When it is time to be applied, nursing staff will remove from double lock box, sign out of book at time of removal, apply the patch on patient and immediately sign off in the eMAR.	9/21/26

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F0684 SS = E	Continued from page 18 Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to maintain effective pain management for one of one resident (20) who was prescribed a Butrans (buprenorphine) transdermal patch (controlled narcotic skin patch that slowly releases an opioid medicine to treat severe pain), which was received from the pharmacy and unaccounted for, resulting in a replacement patch being ordered and subsequently administered late to resident 20. Findings include: 1. Review of the provider's 6/13/26 SD DOH FRI revealed that on 6/12/26, resident 20's ordered Butrans transdermal patch was unaccounted for. The patch was delivered to the facility on 6/8/26 by PharMerica (pharmacy), signed by registered nurse (RN) S, and taken to the medication cart. It was not documented or secured in the locked narcotic storage box within the medication cart. The Butrans transdermal patch was scheduled to be applied on the evening of 6/12/26. RN X reported that when she attempted to retrieve the medication, it was not available and could not be found in the medication treatment cart. RN X notified licensed practical nurse (LPN) Y and resident 20's physician. Assessment of resident 20's skin confirmed she did not have an extra patch applied. A facility-wide search did not locate the patch, and PharMerica confirmed the patch was delivered to the facility. Lumina Care (virtual clinical care service that provided after-hours telehealth) and PharMerica prescribed a replacement Butrans transdermal patch, which was received on 6/13/26 and administered to resident 20 by RN X. The provider's investigation revealed that the loss of the Butrans transdermal patch resulted from the staff's failure to document and secure the controlled substance when it was received from the pharmacy. The medication was never documented in the narcotic count book or placed in the medication cart's narcotic lock box. 2. Review of the PharMerica shipping manifest confirmed resident 20's Butrans 15 microgram (mcg)/hour (hr) transdermal patch was delivered on 6/8/26. 3. Review of resident 20's electronic medical record	F0684	3. The DON/designee will audit receival of Butrans patches weekly for 1 month, bi monthly for 1 month and monthly for 3 months. Audit results will be compiled by the Director of Nursing and presented monthly for three months to the Quality Assurance and Performance Improvement (QAPI) Committee, which includes the Administrator, Director of Nursing, Medical Director, and department managers. 4. 9/21/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2026

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

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F0684 SS = E	Continued from page 19 (EMR) revealed she admitted to the facility on 9/24/24 and had diagnoses including chronic pain (ongoing pain), osteoporosis (weak bones), phantom limb pain (pain from a body part that has been amputated), sciatica pain (sharp pain through your buttock and down one leg), and rheumatoid arthritis (pain, swelling, or stiffness in joints). Her 7/21/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had a 7/23/26 physician's order for a Butrans 15 mcg/hr transdermal patch to be applied every 7 days. The medication administration record (MAR) verified RN S administered the patch on 6/14/26 at 1:27 a.m. 4. Interview on 8/27/26 at 8:31 a.m. with resident 20 revealed she had chronic back pain following multiple surgeries to her back. She reported there have been times when her pain medications were administered late, and she relied on them for pain relief. 5. Interview on 8/27/26 at 3:52 p.m. with RN S revealed she received the Butrans transdermal patch on 6/8/26 but believed it was in a box rather than a plastic bag. She did not open the box, left it in the medication room, and did not follow any process for securing the medication. She stated she did not know the facility's narcotic policy or what was expected when receiving controlled medications. 6. Interview on 8/27/26 with RN X revealed that on 6/12/26 around 6:00 p.m., she attempted to retrieve the resident's Butrans transdermal patch, but it was not in the narcotic lock box. RN X contacted RN S, who could not recall where she had placed the medication. When the second Butrans transdermal patch was delivered by PharMerica, they delivered one patch, and it is placed in a small clear plastic bag. RN X stated the facility did not have a policy on how to receive narcotic medications from the pharmacy at the time of the incident. 7. Interview on 8/28/26 at 9:29 a.m. with director of nursing (DON) B revealed she did not audit the controlled narcotic sheets. She stated the staff was required to use PharMerica's controlled narcotic book to document the narcotic medication counts and that signing the controlled narcotic sheet in the book verified the count was accurate. She expected two nurses to sign PharMerica's shipping manifest upon receiving controlled medications, place the medication in the locked narcotic box in the medication cart, and complete the controlled narcotic	F0684		

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F0684 SS = E	Continued from page 20 book entry. 8. Interview on 8/2/26 at 9:35 a.m. with RN/regional director C, revealed that the Butrans transdermal patch was left on top of the medication cart in the narcotic book by RN S. Previous DON CC, who was no longer employed at the facility, had informed RN/regional director C about the missing patch's location. 9. Previous administrator LL, previous DON CC, and previous LPN Y, who were employed at the facility at the time of the incident, were no longer employed at the facility and not available for an interview. 10. Review of the provider's January 2025 Controlled Medication Storage policy revealed that "Medications included in the Drug Enforcement Administration (DEA) or state classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the nursing care center in accordance with federal, state, and other applicable laws and regulations." "A controlled medication accountability record is prepared when receiving inventory of any controlled substance to establish a record of receipt and disposition in sufficient detail to enable accurate reconciliation. The following information is completed: name of resident, prescription number, name, strength (if designated), and dosage form of medication, date received, quantity received, and name of person receiving medication." "Medication storage conditions are monitored on a regular basis as a random quality assurance (QA) check. As problems are identified, recommendations are made for corrective action to be taken." 11. Review of the provider's May 2025 Resident Handbook revealed that "Medications require a physician's order and are administered on a routine basis." "Pain management: You have an important role in managing your pain. Our policy is to respect and support your right to appropriate pain assessment and management. If you are in pain, your doctor or nurse may ask you to describe your pain in order to determine the appropriate action to take to minimize and manage your pain." 12. Review of the provider's March 2025 Registered Nurse policy revealed "Under general supervision, provides general nursing care to residents in the	F0684		

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F0684 SS = E	Continued from page 21 Community in compliance with state and federal regulations. Works collaboratively with members of the healthcare team. Maintains standards of professional nursing practice." "Obtains and administers prescribed medications and treatments in accordance with approved nursing techniques. Documents same according to Community policy and standards of practice. Interprets, implements, and enforces Community policies and procedures to promote quality of care and to assure resident safety. Demonstrates knowledge of nursing process, particularly as it relates to geriatric residents, long-term care, and rehabilitation"	F0684		
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F0755	1. Resident 20 has had no further issues or concerns with receiving or application of the Butrans patch Resident 11 and 25 have not had any further clerical errors that could potentially result in controlled medications missing. All residents who are prescribed a Butrans patches are at risk for having issues of receiving, proper securing or timely application of the patch. All residents who received controlled medication are at risk for clerical errors that could result in missing medication. 2. Butran patches will come from pharmacy; two nurses will sign on manifest that it has arrived and will immediately take to the medication cart, sign in medication using PharMerica book and put in narcotic lock box. It will remain on cart and counted at every shift change with 2 nursing staff (nurse/nurse or nurse/CMA, CMA/CMA) until it is time to be applied. When it is time to be applied nursing staff will remove from double lock box, sign out of book at time of removal, apply the patch on patient and immediately sign off in the eMAR. Education has been provided to all nursing staff regarding the receiving, proper securing of and timely application of the patch during the FRI that was reported 6/13/2026. There have been no further issues or concerns since that date. New nursing staff will be educated during their first shift. LPN T, CMA V have been educated by 9/21/2026 by the DON on the proper procedure for completing narcotic count with all nursing staff. All nursing staff that are responsible for narcotic count have been educated by 9/21/2026 by the DON/designee on the proper procedure for completing narcotic count with oncoming or off going nursing staff and the importance of signing shift count at time of count being performed and not leaving open signature lines in the book. Those not in attendance due to illness, vacation,and leave of casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift.	9/21/26

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F0755 SS = E	Continued from page 22 This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to ensure controlled substances were secured and accounted for regarding one of one Butrans (buprenorphine) transdermal patch (controlled narcotic skin patch that slowly releases an opiod medicine to treat severe pain) not being secured or available for administration for one of one resident (20) who had chronic pain, and for two of two observed residents (11 and 25) whose controlled medications were missing. Findings include: 1. Review of the provider's 6/13/26 SD DOH FRI revealed that on 6/12/26, resident 20's ordered Butrans transdermal patch was unaccounted for. The patch was delivered to the facility on 6/8/26 by PharMerica (pharmacy), signed by registered nurse (RN) S, and taken to the medication cart. It was not signed or secured in the locked narcotic storage box within the medication cart. The Butrans transdermal patch was scheduled for application on the evening of 6/12/26. RN X reported that the patch was not available and could not be located on the medication cart. RN X reported that the patch was not available and could not be located on the medication cart. She notified previous licensed practical nurse (LPN) Y, resident 20's physician, and resident 20, who was her own power of attorney (POA) (legal document that gives someone else authority to act on your behalf). Resident 20's skin was assessed and revealed that she did not have an extra Butrans (buprenorphine) transdermal patch applied. The medication was confirmed to be missing after a facility-wide search was completed. PharMerica confirmed the medication was sent to the facility. Lumina Care (virtual clinical care service that provides after-hours telehealth) and PharMerica prescribed a replacement Butrans transdermal patch for resident 20, which was received on 6/13/26 and administered to the resident by registered nurse (RN) S. The investigation concluded that the loss resulted from the staff's failure to properly document and secure the controlled medication when it was	F0755	3. The DON/designee will audit receival of Butrans patches weekly for 1 month, bimonthly for 1 month and monthly for 3 months. The DON/designee will audit Pharmacy narcotic log books to ensure proper time of administration and documentation has occurred and that there are no signature lines left blank. Audits will be weekly for 1 month, bimonthly for 1 month and monthly for 4 months. Audit results will be compiled by the Director of Nursing and presented monthly for three months to the Quality Assurance and Performance Improvement (QAPI) Committee, which includes the Administrator, Director of Nursing, Medical Director, and department managers. 4. 9/21/2026	

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F0755 SS = E	Continued from page 23 received from the pharmacy. It was never documented in the narcotic count book or secured in the narcotic lock box in the medication cart as required. 2. Review of the PharMerica shipping manifest confirmed resident 20's Butrans 15 microgram (mcg)/hour (hr) transdermal patch was delivered on 6/8/26. 3. Review of resident 20's electronic medical record (EMR) revealed she admitted to the facility on 9/24/24 and had diagnoses including chronic pain (ongoing pain), osteoporosis (weak bones), phantom limb pain (pain from a body part that has been amputated), sciatica pain (sharp pain through your buttock and down one leg), and rheumatoid arthritis (pain, swelling, or stiffness in joints). Her 7/21/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had a 7/23/26 physician's order for a Butrans 15 micrograms per hour to be applied once every 7 days for pain management, with the previously placed patch to be removed at the time of the new application. Her medication administration record (MAR) indicated that the Butrans transdermal patch was administered on 6/14/26 at 1:27 a.m. by RN S. 4. Interview on 8/27/26 at 8:31 a.m. with resident 20 revealed she had chronic back pain following multiple surgeries to her back. She reported there have been times when her pain medications were administered late, and she relied on them for pain relief. 5. Interview on 8/27/26 at 3:52 p.m. with RN S revealed she received the Butrans transdermal patch from PharMerica on 6/8/26 for resident 20. She thought the patch was in a box and not a plastic bag. She did not know exactly what was labeled on the box or what was in it, as she did not open the box. She left the box in the medication room and did nothing else with the medication. RN S did not know the provider's policy on narcotics or what was expected of her when she received a narcotic from the pharmacy. 6. Interview on 8/27/26 with RN X revealed that on 6/12/26 around 6:00 p.m., when she went to retrieve the Butrans (buprenorphine) transdermal patch for resident 20, she found it was not in the locked box within the medication cart. She had checked the treatment cart, and it was not there either. She called RN S to ask where she had put the Butrans	F0755		

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F0755 SS = E	Continued from page 24 (buprenorphine) transdermal patch, but the nurse could not recall what she had done with it. She stated the facility did not have a policy for receiving controlled narcotic medications from the pharmacy when this incident had occurred. 7. Interview on 8/28/26 at 9:29 a.m. with director of nursing (DON) B revealed she did not conduct audits of the controlled narcotic sheets. She stated that the staff was required to use PharMerica's controlled narcotic book to document narcotic medication counts, ensuring the medication quantities matched the recorded totals. She stated that signing the controlled narcotic sheet verified the narcotic count. She expected that when narcotic medications arrived from the pharmacy, two nurses were to sign the shipping manifest, and place the narcotic medication in the locked narcotic box within the medication cart. The nurse who received the narcotic medication would then complete the corresponding entry in the controlled narcotic book. 8. Interview on 8/2/26 at 9:35 a.m. with RN, regional director C, revealed that the Butrans transdermal patch was left on top of the medication cart in the narcotic book by RN S. Previous DON CC, who was no longer employed at the facility, had informed RN/regional director C about the missing patch's location. 9. The previous administrator LL, previous DON CC, and LPN Y, who were employed at the facility at the time of the incident, were no longer employed at the facility and not available for an interview. 10. Review of the provider's January 2025 Controlled Medication Storage policy revealed that "Medications included in the Drug Enforcement Administration (DEA) or state classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the nursing care center in accordance with federal, state, and other applicable laws and regulations. A controlled medication accountability record is prepared when receiving inventory of any controlled substance to establish a record of receipt and disposition in sufficient detail to enable accurate reconciliation. The following information is completed: name of resident, prescription number, name, strength (if designated), and dosage form of medication, date received, quantity received, and name of person receiving medication. Medication storage conditions are monitored on a regular basis as a random quality assurance (QA) check. As problems are identified, recommendations are made for corrective action to be taken."	F0755		

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F0755 SS = E	Continued from page 25 11. Observation and review of the provider's Controlled Substance Book on 8/27/26 at 1:59 p.m. with contracted travel licensed practical nurse (LPN) T revealed nurses and certified medication aides (CMAs) reconciled scheduled and as-needed controlled medications (the process of comparing the medical record against an inventory of medication to prevent errors such as omissions, duplications, or incorrect dosages) at the beginning and end of the day, evening, and night shifts. After verifying the available quantity of the controlled medications, the nurses and CMAs signed the provider's Controlled Substance Book to accept accountability of the medications during their shift. Each medication cart (A and B) had two signature books, one for scheduled medications and one for as-needed medications. All four signature books were missing multiple staff signatures during the months of June, July, and August 2026. Contracted travel LPN T stated that the process of signing the Controlled Substance Book varied among the staff, depending on preference. "Some staff sign it at the beginning of their shift, but I like to sign it at the end of my shift to make sure everything is correct." She did not know who was responsible for ensuring that the staff signed the book on each shift. 12. Observation, review of the Controlled Substance Book, and EMR review on 8/27/26 at 4:41 p.m. with CMA V revealed that the medication count for resident 11's as-needed Lorazepam (a medication used to treat anxiety) was off by one pill. According to the Controlled Substance Book, there should have been 16 Lorazepam 0.5 milligram (mg) pills in the resident's medication card, but there were only 15. The medication count for resident 25's scheduled Hydrocodone Acetaminophen (a medication used to manage moderate to severe pain) was off by one pill. According to the Controlled Substance Book, there should have been 29 Hydrocodone Acetaminophen 5-325 mg pills in the resident's medication card, but there were only 28. 13. Interview on 8/27/26 at 5:14 p.m. with CMA V revealed that if the medication counts were off, she would search the entire medication cart to see if any pills came loose from the medication card. She did	F0755		

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F0755 SS = E	Continued from page 26 this and did not find resident 11 and 25's missing pills. She stated she would tell the charge nurse or director of nursing (DON) B about the discrepancy. CMA V said that when counting medications, she would say the number of counted pills in the medication card while the other nurse or CMA verified the number in the Controlled Substance Book. She said she had verified the medication count with registered nurse (RN) S at the start of her shift that day (8/27/26). "To my knowledge, it was accurate this morning." 14. Interview and EMR review on 8/27/26 at 6:06 p.m. with DON B revealed she had identified a clerical error that resulted in the medication count discrepancy for resident 25's Hydrocodone Acetaminophen. The error occurred on 8/26/26 at 5:00 p.m. when RN S administered a Hydrocodone Acetaminophen to resident 25, documented it in the resident's EMR, but did not document it in the Controlled Substance Book. 15. Interview and EMR review on 8/28/26 at 9:30 a.m. with DON B revealed she had identified a second clerical error that resulted in the medication count discrepancy for resident 11's Lorazepam. The error occurred on 8/27/26 at 8:00 a.m. when CMA V administered a Lorazepam to resident 11, documented it in the resident's EMR, but did not document it in the Controlled Substance Book. DON B felt that if she did not investigate the medication count discrepancy for these two medications, the clerical errors would have eventually been noticed by the evening shift staff. She stated that it was a frustrating system and that incorrect medication counts have happened one other time that she knew of. There were 10 nursing staff members who attended an in-service education meeting by PharMerica (pharmacy provider) on 8/20/26 to learn about safe medication administration and controlled substance reconciliation processes. Aside from the pharmacy in-service meeting, DON B said she did not perform competency testing for controlled substance reconciliation. She felt the process could improve if both nurses have eyes on the number of pills in the resident's medication pack and the count documented in the Controlled Substance Book.	F0755		

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F0755 SS = E	Continued from page 27 "They need to take accountability of both numbers." DON B said the resident care manager is responsible for auditing the Controlled Substance Book to ensure the staff are correctly counting medications and signing the book each shift. The facility did not currently have anyone hired for that role, so DON B assumed those responsibilities. 16. Review of the provider's January 2026 Medication Administration Policy revealed that each medication administration is documented in the resident's EMR or medication administration record (MAR) (a log used to track all the medications given to a patient) by the person administering the medication. The staff's initials on each resident's MAR were verified with a full signature in the space provided in the Controlled Substance Book or on the nursing care center's master employee signature log.	F0755		
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint review, interview, observation, documentation review, and policy review, the provider failed to ensure that food was palatable (having a pleasant taste or being acceptable and easy to accept), appetizing, and warm when served to all residents who ate meals in their rooms and in the dining room. Findings include: 1. Review of the 7/9/26 SD DOH complaint revealed that the complainant was a resident at the facility in May and June of 2026. The complainant stated that	F0804	1. Corrective Action 50,51,28,44 and attendees of resident council on 2/24, 3/31,7/28, and 8/24 were notified of plate warmer order and dietary staff educated on serving meals at proper temp and ensuring meat is cooked to remain palatable and reduce risk of meat becoming "tough" 2. Dietary Manager will add plate warmer to all meal services, additionally a closed Cambro cart will be used to serve in-room meals to maintain appropriate temperature. Dietary Manager educated all dietary employees on proper food temps and maintaining food temps as well as appropriate prep to avoid tough meat. Those not in attendance due to illness, vacation,and leave of casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. 3.Dietary/Designee will audit Palatability/Prefer Temps 3x/week for 4 weeks, weekly for 1 month, then monthly x3 months. Results of these audits will be brought to QAPI for review and recommendation. 4. 9/21/2026	9/21/26

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	**611 EAST 2ND AVE , FLANDREAU, South Dakota, 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
F0804 SS = E	Continued from page 28 there was a "large outbreak of diarrhea that may or may not have been related to food not being served at appropriate holding temperatures," that the food was "frequently served cold," and that the food "was placed on carts and sat too long before it was served." The complainant indicated that the second floor was served first and the first floor was served last. 2. Interview on 8/25/26 at 11:25 a.m. with residents 50 and 51 in their shared room revealed that they ate their meals in their room. They felt the food was cold, the meat was often "tough," and sometimes it was "undercooked." Resident 51 stated they often received lunch at 1:15 p.m. and wondered how long their meals waited on the cart to be served. 3. Interview on 8/25/26 at 12:25 p.m. with resident 28 revealed that he did not like the meat and mashed potatoes, so he only ate the bread pudding dessert. He said he rarely liked the noon meal, so at breakfast he ordered two egg sandwiches, hot cereal, and three glasses of chocolate milk to stay full until supper. 4. Observation on 8/25/26 at 12:32 p.m., in the main dining room, revealed that the dietary staff loaded twelve plates of food with insulated tops and bottoms onto an open wheeled cart. At the bottom of the cart were beverages, including juice and milk, covered with a tray. These meals were delivered to the first floor at 12:35 p.m. The last of those plates of food and a beverage were delivered to a resident at 12:52 p.m. 5. Observation on 8/25/26 at 12:48 p.m. in the main dining room revealed that resident 28, who appeared frustrated, was leaving the dining room. He stated to a staff member that the chicken was terrible, that he was going to his room, and that he wanted to be left alone. 6. Interview on 8/25/26 at 2:38 p.m. with resident 28 in his room revealed that he thought the food was "awful," that everyone knew it, and stated, "Go talk to the other residents, and you will hear the same thing." He did not want to discuss his concerns because "nothing will come from it." 7. Interview on 8/25/26 at 3:44 p.m. with resident 44	F0804		

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F0804 SS = E	Continued from page 29 in his room revealed he ate most of his meals in the dining room. He stated, "The food is not good." He stated that the food was bland and cold, and the meat was hard to chew. He believed the dietary staff was aware of the residents' concerns about the food because residents complained to one another all the time. He did not report his concerns to the dietary department. 8. Review of the monthly 2/24/26 through 8/24/26 resident council minutes revealed that on 2/24/26, twelve residents (1, 2, 3, 7, 25, 29, 34, 36, 57, 71, 72, and 73) and dietary supervisor (DS) E, activities director (AD) G, and previous administrator LL, attended the resident council meeting. Resident concerns included "cold food" and "tough and dry meat." Discussion of new business related to the dietary department indicated, "Things are better. Depends on [the] cook for [the] temp [temperature] of [the] food." On 3/31/26, nine residents (1, 3, 9, 15, 25, 29, 31, 34, and 57) and AD G attended the resident council meeting. Resident 3 indicated he did not care for certain cooks' food. On 7/28/26, thirteen residents (1, 2, 3, 7, 9, 15, 25, 29, 33, 34, 36, 42, and 57) and AD G attended the resident council meeting. Discussion of new business related to the dietary department indicated "Cold Food." On 8/24/26, fourteen residents (1, 2, 8, 9, 15, 20, 24, 25, 31, 34, 38, 42, 57, and 61) and AD G attended the resident council meeting. Resident concerns included "still cold food." Discussion of new business related to the dietary department indicated, "No meal of the month for [the] last two months…want real butter and in a bigger pack, more food options." 9. Review of the provider's February 2026 through August 2026 grievance forms revealed that on 5/20/26, resident 68 completed a grievance form indicating that he wanted a microwave for his room because his "food was always cool to cold." The action taken was that maintenance director DD "explained to resident [68] that it was not possible." Regional vice president of operations (RVPO) D discussed resident 68's concerns with DS E and followed up with resident 68 on 5/26/26 and	F0804		

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F0804 SS = E	Continued from page 30 5/27/26, indicating, "Resident [68's] food [was] hot [for the] last 3 meals." On 5/6/25, resident 68 completed a grievance form indicating that he was receiving cold room trays and not receiving the items he requested. The actions taken included DS E meeting with resident 68 to set up his menu for the week. He was offered the option to eat meals in the dining room and declined, indicating he "would prefer to eat in room," and that he would be served first at all meals. On 6/12/26, residents 50 and 51 completed a grievance form indicating they "got a cold dessert on top of a hot meal," and that the "Jell-O was placed under the dome lid and was melted onto the main dish." The actions taken included DS E educating the dietary aides not to place cold desserts under the dome lid and to "be mindful of quality when delivering" the resident's meals. 10. Interview on 8/26/26 at 10:00 a.m. with the resident council group revealed that nine residents (1, 15, 20, 24, 25, 29, 34, 57, and 61) who regularly attended the facility resident council meeting were present. All residents present confirmed that they were frustrated about the meals they were served. One resident stated, "The food is cold, it tastes bad, and there is no choice." All residents confirmed they had concerns about receiving cold food when they ate in their room and in the dining room. Their concerns were occurring for several months, and they had shared their concerns at the resident council meetings. The food would get better for a few days, and then the food would be cold again. One resident who did not want to be identified stated she was served mashed potatoes so cold they seemed "like they came directly from the refrigerator." Another resident who did not want to be identified stated he was served chicken last night "so tough I couldn't cut it, never mind chew it." The resident council group agreed that hot meals were colder when served in their rooms, but that some hot meals were served cold even in the dining room. They acknowledged that the new DS E met with the resident council group for a "Chef Talk"	F0804		

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F0804 SS = E	Continued from page 31 recently, but felt that they continued to receive meals in their rooms that were cool or cold when they received them. 11. Interview on 8/26/26 at 11:14 a.m. with AD G confirmed that she facilitated the resident council meetings, that the residents had many concerns about the meals they were served, and that "food was brought up more than once recently." The resident council minutes were approved by administrator A each month. AD G indicated that more than one administrator was made aware of the resident council group's concerns with the food. DS E attended a resident council meeting a few months ago, but resident concerns about cold food and tough meat were discussed again at the August meeting. 12. Observation on 8/26/26 at 5:30 p.m. revealed that the chicken strips that were served for supper were hard and slightly burned. Many of the residents chose not to eat the chicken strips and left them on their plates. 13. Observation on 8/27/26 at 8:24 a.m. revealed that 10 breakfast meals were delivered to the first floor for the residents who resided on the first floor. A "test" breakfast meal was ordered by the surveyor to contain one serving of each item served to the residents, and to be brought to the surveyor after the last resident's breakfast meal was delivered. The last resident breakfast meal was delivered at 8:56 a.m. The "test" breakfast meal temperatures were checked on the food delivery cart on the first floor and included French toast that was 104 degrees Fahrenheit (F), hot cereal that was 119 degrees F, eggs that were 98 degrees F, sausage that was 89.7 degrees F, and milk that was 55 degrees F. 14. Interview and review of the food temperatures observed above on 8/27/26 at 10:17 a.m. with DS E and registered dietitian (RD) J revealed that they were aware of resident concerns about cold food and had attended a resident council meeting a few months ago, where residents shared concerns about the food temperatures and the meat. DS E stated that a cook they thought was having a "hard time meeting performance standards" no longer worked at the facility and believed the issue was improving. She monitored the temperature of the food in the steam table but felt she had little control over its temperature once it left the steam table. She	F0804		

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F0804 SS = E	Continued from page 32 expected the hot resident meals to be served hot. The nursing staff was responsible for delivering the resident meal plates once the dietary staff members delivered the cart to the floor. DS E and RD J were not aware of the temperature of the food when it was served to the residents and agreed that the above-temperature foods were not "palatable," were surprised how quickly the foods had lost their initial temperature, and expected the meat to be "warmer than that" and the milk to be "cold." They were unsure what temperature the food should have been when it was served. DS E stated that she had requested that the facility purchase a plate warmer and the thermal inserts for the insulated plate base and thought they were ordered. 15. Interview and Performance Improvement Plan (PIP) document review with DS E on 8/27/26 at 2:51 p.m. revealed that she was working on improvements in the kitchen but did not document those efforts until that day (8/27/26). She confirmed the documented dietary department PIP areas were not directly related to the resident's food temperatures or to addressing the residents' concerns about receiving cold food in their rooms. 16. Interview and email documentation review on 8/28/26 at 10:49 a.m. with RVPO D revealed that on 8/18/26 RVPO D received an email from divisional dietitian JJ that stated, "Is it possible to get [provider's initials redacted] a plate warmer? I have been trying since I started to get one. They have cold food complaints in [resident] rooms." RVPO D replied, "Yes, I just need a couple Bids..." RVPO D stated that she knew there were resident complaints about receiving cold food "a while ago," had thought that those complaints were resolved, and did not order the plate warmer. 17. Review of the provider's December 2025 Resident Handbook revealed "Our center provides at least three meals a day, and supplemental snacks are available between meals and at bedtime. We encourage all residents to eat in the dining room, which is designed for a pleasant dining experience." "Our nutrition program provides menus featuring fresh and nutritious meals. You will be provided with regular, well-prepared meals, as ordered by your physician and in accordance with established national guidelines."	F0804		

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F0804 SS = E	Continued from page 33 18. Review of the provider's October 2017 Food Temperature policy revealed that "Food Temperatures are taken and documented daily prior to meal service and monitored periodically throughout the meal service." The policy did not include monitoring the temperatures of the resident meals served in their rooms. 19. Review of the provider's July 2008 Serving Food policy revealed that "Food is prepared and served in a manner that meets the needs of the resident." The procedure of "Residents Eating in Their Rooms" was that "The Dietary Department prepares the food cart for delivery. The nursing staff takes [the] food trays into the resident's room. Nursing Services picks up the resident's food tray after each meal and returns the food cart to the Dietary Department. Tray setup is done by nursing and assistance [is] provided as needed." The policy did not include monitoring the temperatures of the resident meals served in their rooms.	F0804		
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F0561	1. Resident 37, 56, and 67 bathing preferences have been reviewed and updated in care plan as needed. Baths have been given per patient preference. All other residents are at risk for not receiving baths per their bathing preference or not receiving a bath within 72 hours of admission. 2. The nurse completing the resident admission assessment will be responsible for asking about resident personal bathing schedule preference on admission. The nurse will work with the bath aide to get the resident added to the schedule per the resident preferences. The resident will receive their first bath within 72 hours of admission and this bath may not correlate to preference stated upon admission. Education was provided to Nursing staff and the bath aide on the process by the DON by 9/21/2026. Those not in attendance due to illness, vacation, and leave of casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. 3. The DON or designee will audit resident bathing preference of all new admissions. The DON/designee will audit to ensure the resident has received their first bath within 72 hours of admission and to ensure bathing is happening per resident bathing preferences. Audits will be completed WeeklyX4, Bimonthly X2, and monthly X4. All Audits will continue until compliance has been maintained for three months. Results of these audits will be discussed by the DON/designee at the QAPI meetings with the IDT and medical director for analysis and recommendations for continuation, discontinuation, or revision of audits based on findings.	9/21/26

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F0561 SS = D	Continued from page 34 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the staff protected the residents' sense of dignity for three of four sampled residents (37, 56, and 67) by assisting them with bathing once per week. Findings include: 1. Observation on 8/18/26 at 3:36 p.m. of resident 37 in the dining room revealed she had long hair that reached just below her shoulders. Her hair appeared greasy and was stuck to the top of her head. 2. Review of resident 37's electronic medical record (EMR) revealed she admitted to the facility on 1/6/26. Her documented bathing record indicated she preferred Fridays as her bath day and required the assistance of one staff member. There was no documentation of bathing care for her from 5/29/26 through 6/12/26 (12 days), and from 8/7/26 through 8/21/26 (14 days). 3. Review of resident 56's EMR revealed she admitted to the facility on 5/22/26. Her documented bathing record indicated she preferred Fridays as her bath day and required the assistance of three staff members. There was no documentation of bathing care for her from 6/19/26 through 7/3/26 (14 days). 4. Review of resident 67's EMR revealed she admitted to the facility on 6/17/26 and discharged on 6/22/26. Her preference for the day of bathing was not documented, and there was no documentation of bathing care during her stay at the facility. 5. Interview on 8/28/26 at 9:14 a.m. with registered nurse (RN)/regional director C stated that there was no documentation that resident 67 received bathing care during her stay. She stated that there may be more information regarding the residents' baths being completed and that she would provide that information. There was no additional information provided that was different from the above documented bathing records.	F0561	4. 9/21/2026	

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F0561 SS = D	Continued from page 35 6. Review of the provider's March 2026 Skin Integrity policy revealed there was no information regarding bathing care.	F0561		
F0583 SS = D	Personal Privacy/Confidentiality of Records 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 observation, interview, and policy review, the provider failed to ensure the residents' right to privacy and confidentiality of protected health information (an individual's health, treatment, and payment information, also known as PHI) was protected by registered nurse (RN) S, who left two of two residents' (31 and 59) medication administration records (MARs) visible on an unattended computer	F0583	1. Resident 31 and 59 resident Private Health Information (PHI) were not compromised by being left open and visible in an area accessible to anyone who passed by on an unattended computer . All other residents have the potential of being affected by having their PHI compromised when an unattended computer has been left open and visible in an area accessible to anyone who passed by. 2. RN S has been educated that leaving PHI unsecured when computer is unattended in not acceptable and necessary safeguards of locking the screen and closing the computer are safe ways to protect PHI during a medication pass. All other Nursing staff have been educated that leaving PHI unsecured when computer is unattended in not acceptable and necessary safeguards of locking the screen and closing the computer are safe ways to protect PHI during a medication pass. Those not in attendance due to illness, vacation, and leave of casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. 3. The DON or designee will randomly observe computers during medication pass to ensure PHI is not visible or left unattended on a computer during medication pass. The audits will be completed 5 times a week for 1 week, 3 times a week for 1 week, and twice a week for two weeks, twice a week every other week, and then twice a month for 3 months. Results of these audits will be discussed by the DON/designee at the QAPI meetings with the IDT and medical director for analysis and recommendations for continuation, discontinuation, or revision of audits based on findings. 4. 9/21/2026	9/21/26

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F0583 SS = D	Continued from page 36 in an area accessible to anyone who passed by. Findings include: 1. Observation on 8/26/26 from 3:25 p.m. to 3:34 p.m. of RN S standing at the east hall medication cart outside of resident 11's room revealed she gave two Ibuprofen tablets to resident 31 as he sat in a wheelchair next to the cart. After resident 31 swallowed the two tablets, RN S locked the medication cart and walked around the corner to a sink near the kitchen to wash her hands, leaving the computer screen on the medication cart open with resident 31's MAR visible to four guests who were talking to resident 31 next to the cart. At 3:26 p.m., RN S returned to the cart, noticed the visible MAR, and said, "Oh, I forgot." She then closed the MAR on the screen. At 3:30 p.m., RN S placed two Acetaminophen tablets in a medicine cup and walked to resident 59's room, leaving the bottle of Acetaminophen and the computer screen displaying resident 59's MAR unattended on the cart. RN S gave the two tablets to resident 59, who was in her bed, washed her hands in the room, and returned to the cart. She clicked on the computer screen and said, "Oh, I forgot to get her pain rating." RN S walked back to resident 59's room, leaving the bottle of Acetaminophen resident 59's visible MAR unattended. She asked resident 59 to rate her pain, then walked past the unattended cart to the nurse's station to speak with RN X. At 3:34 p.m., RN S returned to the medication cart, documented resident 59's pain rating, locked the computer screen, and placed the Acetaminophen bottle back into the medication cart. 2. Interview on 8/26/26 at 4:42 p.m. with RN S indicated she normally closed or locked the computer screen and secured all medication before walking away from the medication cart. She stated, "I just forgot today." 3. Interview on 8/28/26 at 10:00 a.m. with director of nursing (DON) B revealed she expected the staff to lock the computer screen when stepping away from the medication cart. She said it was not acceptable to leave medication or open computer screens on an unattended cart. 4. Review of the provider's January 2026 Medication	F0583		

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(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
F0583 SS = D	Continued from page 37 Administration policy revealed that "medication administration records containing resident health information must not be visible when not in direct use (paper MAR closed, electronic health record information hidden)."	F0583		
F0610 SS = D	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 by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to investigate a staff-reported incident of potential resident abuse regarding one of one previous contracted travel certified nursing assistant (CNA) (BB) who allegedly pulled one of one residents' (56) wheelchair backward into the bathroom with resident (56) sitting in it, causing the resident's leg to get caught under the wheelchair wheel, which caused her to have pain. Findings include: 1. Review of the provider's 6/9/26 SD DOH FRI revealed alleged abuse between previous contracted travel CNA BB and resident 56 occurred on 6/8/26 at 8:30 p.m. The report was completed by previous director of nursing (DON) CC. According to the FRI, previous contracted travel CNA BB yelled at resident 56 while they pulled the	F0610	1. Resident 56's time has lapsed for a thorough and complete investigation to be completed. DON CC no longer works at the facility. All residents are at risk for the potential of abuse resulting in a staff reported incident. 2. New checklists have been created to provide detailed instruction of what should be used to complete a thorough investigation, Administrator and DON reviewed the Abuse and Neglect Policy, Abuse Investigation Policy, Abuse Investigation Pathway and the DOH Conducting an Investigation power point. These materials have been put in a binder for the Administrator and DON to use for reference for each investigation needing to be completed. Education was provided to the DON and Administrator by the RDCO on 9/21/2026. 3. The administrator will review each allegation of abuse and ensure the DON has completed a thorough and timely investigation prior to submitting the final to the SD DOH. The validation will be used by utilizing the tools above in the binder provided. The RDCO will randomly audit 3 abuse allegations/reports each month to ensure the DON is following facility guidance for how to complete an investigation. Audits will continue for 6 months. Results of these audits will be discussed by the DON/designee at the QAPI meetings with the IDT and medical director for analysis and recommendations for continuation, discontinuation, or revision of audits based on findings. 4. 9/21/2026	9/21/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2026

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F0610 SS = D	Continued from page 38 resident backward in their wheelchair to the bathroom. The resident had yelled "ow, my leg," and previous contracted travel CNA BB yelled back, "stop fighting me." CNA GG had intervened and fixed the resident's leg, which was stuck under the front wheel of the wheelchair, and placed it back on the foot pedal. Resident 56's range of motion was assessed and was within normal limits, and the resident denied having any pain during the assessment. The staff was provided with abuse and neglect education to ensure they reported abuse and neglect incidents on time. 2. Review of the provider's investigation file included a copy of the FRI submitted to SD DOH, handwritten statements from previous contracted travel CNA BB and CNA GG, a "Rehab Communication to Nursing" dated 6/10/26 regarding resident 56 and to change her transfer technique to an EZ [a mechanical stand used to assist someone from a seated position to an upright standing posture] stand with the assistance of three staff members. There was no other information provided regarding the alleged abuse. The written statement from previous contracted travel CNA BB indicated she was getting resident 56 into a nightgown. Previous contracted CNA BB denied yelling at anyone or saying anything "wrong." The written statement from CNA GG indicated that previous contracted travel CNA BB was the perpetrator, and registered nurse (RN) X came into the room during the time of the alleged incident. There were no statements or interviews from other staff members on duty, including RN X, or from any residents. 3. Review of resident 56's electronic medical record (EMR) revealed her 6/5/26 Brief Interview of Mental Status assessment score was a three, indicating that her cognition was severely impaired. There was no documentation in her EMR indicating that she was assessed for injury by RN X after the incident on 6/8/26. 4. Interview and review of the 6/9/26 SD DOH FRI on 8/27/26 at 3:02 p.m. with director of nursing (DON) B and RN/regional director C regarding investigating allegations of abuse revealed the nurse was to complete an initial assessment of the residents and document the information into the provider's risk management system. DON B would complete an internal investigation. This would	F0610		

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F0610 SS = D	Continued from page 39 include interviewing residents who were cognitively aware, nurses, and anyone else who may have been involved in the incident. She would call the police department, Ombudsman, and the South Dakota Department of Health. The employee would be suspended until the investigation was complete. They were not aware of why this process was not followed for this incident, as neither of them were employed at that time. 5. Interview on 8/26/26 at 3:28 p.m. with administrator A regarding resident 56's 6/8/26 incident revealed administrator A was not employed at the time of the incident. She stated that the investigation file she provided was the only information available regarding the incident. 6. Review of the provider's October 2022 Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation policy revealed that 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. "(Refer to Abuse Investigation Policy)" 7. Review of the provider's October 2022 Abuse Investigation policy revealed that "The Center conducts a thorough investigation of potential, suspected and/or allegations of abuse, neglect, and exploitation of residents..." "The Executive Director is the designated abuse coordinator and is responsible for assigning and overseeing staff that are to assist with investigations." "The Center identifies and interviews involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations." "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." "The Center maintains complete and thorough documentation of the investigation."	F0610		

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F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F0655	1. Resident 13 and 67 times have passed for baseline care plan to be corrected. Comprehensive care plans for Resident 13 and 67 have been reviewed and revised to reflect resident current needs and plan of care. All newly admitted residents are at risk for potential safety concerns and disruption of continuity of care due to baseline care plans not being completed, copied and reviewed by resident or resident representative within 48 hours. 2. The floor nurses will ensure the base line care plan is complete within 48 hours of admission. Education was provided to the floor nurses regarding proper completion of the Nursing Admission Assessment to ensure the baseline care plan is complete and accurate, and that areas need to be properly completed to flow to the baseline care plan. Education was provided by the DON by 9/21/2026. Those not in attendance due to illness, vacation, and leave of casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. 3. The DON or designee will audit all New Admission Nursing Assessments and baseline care plans within 48 hours of admission to ensure baseline care plan has been completed, copied and reviewed by resident or resident representative. Audits will be completed WeeklyX4, Bimonthly X2, and monthly X4. All Audits will continue until compliance has been maintained for three months. Results of these audits will be discussed by the DON/designee at the QAPI meetings with the IDT and medical director for analysis and recommendations for continuation, discontinuation, or revision of audits based on findings. 4. 9/21/2026	9/21/26

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F0655 SS = D	Continued from page 41 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to develop a person-centered baseline care plan (personalized plan that addresses a resident's care needs, goals, and interventions) that included the minimum healthcare information necessary to care for one of four sampled newly admitted resident (13) and that the baseline care plan was reviewed with, and a copy was offered to the resident or the resident's representative within 48 hours of the resident's admission to the facility for two of four sampled newly admitted residents (13 and 67). Findings include: 1. Review of resident 13's electronic medical record (EMR) revealed that she admitted to the facility on 6/10/26. Her diagnoses included Type 2 Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar), anxiety, and fractures of her sacrum (tailbone) and left femur (upper leg). Her 8/11/26 Brief Interview for Mental Status (BIMS) assessment score was 6, which indicated her cognition was severely impaired. Resident 13's 6/10/26 Braden Scale for Predicting Pressure Sore Risk (a tool used to assess the risk of developing pressure ulcers) scores indicated that she was "AT RISK" for developing a pressure ulcer. A 6/10/26 Admission Skin/Wound Evaluation revealed that resident 13 was admitted to the facility with a right calf (back of lower leg) non-pressure injury and a left hip surgical incision. Her Treatment Administration Record (TAR) indicated that on 6/10/26, her baseline plan of care was offered to her or her representative. Her baseline care plan did not contain the level of staff assistance she required for bathing, dressing, or eating, her social services needs, or interventions to prevent the development of pressure ulcers.	F0655		

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F0655 SS = D	Continued from page 42 2. Interview and review of resident 13's care plan on 8/28/26 at 9:40 a.m. with licensed practical nurse (LPN)/Minimum Data Set (MDS) I revealed the baseline care plan was "triggered automatically" in the EMR when the resident's admission assessment was completed. He expected the nurse who completed the resident's admission assessment to answer the questions correctly to "trigger" each area that needed to be included in the baseline care plan and to document in the TAR that it was offered to the resident or their representative. He expected "all of the required areas" to be on the resident's baseline care plan but was unsure which areas were required. He was unable to determine whether all the required areas were included in resident 13's baseline care plan because it appeared that not every area was "triggered." He expected the resident's baseline care plan to be reviewed with the resident and/or their representative when the admission nursing assessment was completed, and a copy of the baseline care plan to be printed for the resident or their representative if they requested one. He confirmed that the TAR did not indicate what information was on the baseline care plan when it was reviewed with the resident, or if the resident or their representative was provided a copy. 3. Review of resident 67's electronic medical record revealed she admitted to the facility on 6/17/26. Her 6/22/26 BIMS assessment score was 14, which indicated her cognition was intact. Her TAR indicated that on 8/3/26 her baseline plan of care was offered to her or her representative. 4. Interview on 8/26/26 at 4:02 p.m. with registered nurse (RN)/regional director C regarding the resident's baseline care plan revealed that the documentation indicating the baseline care plan was developed and offered to the resident or their representative within 48 hours of admission was documented on the residents' TAR. She indicated that if the +/- was documented, it meant that the baseline care plan was offered to the resident or their representative or that it was refused by the resident or their representative. Regarding resident 56's documented "y" she believed that also meant that the resident or their representative was offered the baseline care plan. She confirmed there was no documentation in the residents' 11, 56, and 67's EMRs to confirm who had received the baseline care plan.	F0655		

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F0655 SS = D	Continued from page 43 5. Review of the provider's July 2025 Baseline Plan of Care policy revealed: "The facility develops the baseline plan of care for each resident, within 48 hours of admission." "A summary or a copy of all components of the baseline plan of care, and the initial goals of the resident, is offered to the resident/Representative." "The licensed nurse initials on the TAR, indicating that the BPOC was offered and either accepted or declined."	F0655		
F0726 SS = D	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by:	F0726	1. Resident 67 no longer resides in the facility. All residents that have Peripherally Inserted Central Catheters (PICC) are at risk for having nursing staff that have not received necessary guidance, provider direction, and competency support for the care of a resident with a PICC. Resident record review from 8/28/2026 to current has identified that no residents have been admitted or are currently in the facility that have a PICC. 2. DON will review all new admissions prior to entering the facility to validate if they have a PICC and will review the schedule to ensure the staff that are present on day of admission and staff that will be working during the resident stay have received education, competency and any refreshers that are needed prior to the resident being admitted. Once education has been completed with staff it is there responsibility to discuss discomforts or concerns with the PICC with the DON and or RCM's on staff to ensure any questions or concerns have been addressed prior to or during the care of the resident with a PICC. RN KK, RN S, and RN X have all received education and performed competency in the management and care of a PICC line. All other licensed nursing staff have received education and performed competency in the management and care of a PICC by 9/21/2026 by the DON. Newly hired or contract nurses will be reviewed, educated and perform competency prior to caring for a resident that has a PICC. Those not in attendance due to illness, vacation, and leave of casual work status will not be allowed to work until the education has been completed prior to the admission of a resident with a PICC. 3. The DON will review admissions and readmission prior to being admitted validating if a PICC will need to be cared for and managed. When a resident resides in the facility with a PICC the DON will complete 3 nurse interviews who are caring for the resident with a PICC a week while the PICC remains in use, until removed or the resident has been discharged from the facility to ensure trouble shooting, questions, and or concerns have been addressed.	9/21/26

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F0726 SS = D	Continued from page 44 Based on interview and record review, the provider failed to ensure registered nurse (RN) KK staff received necessary guidance, provider direction, and competency support for the care of a resident with a peripherally inserted central catheter (PICC) that could not be accessed, for one of one resident (67) reviewed for vascular access device care. This failure resulted in a lack of appropriate and timely nursing intervention and had the potential to compromise the resident's safety and treatment needs. Findings include: 1. Review of resident 67's closed electronic medical record (EMR) revealed she admitted to the facility on 6/17/26. She went to a clinic appointment on 6/22/26 and was admitted to the hospital from that appointment, as she refused to return to the provider's facility. Resident 67's diagnoses included right artificial knee joint, right knee infection, cellulitis of right lower limb, type 2 diabetes, and sepsis. Resident 67's 6/17/26 physician orders included ceftriaxone sodium-dextrose (antibiotic) intravenous (IV) (within a vein) solution to be administered every 24 hours for infection of prosthetic knee joint until 6/23/26. Resident 67 had a PICC line for this to be administered through. Review of resident 67's 6/17/26 hospital notes revealed that the hospital did not administer the antibiotic before discharging resident 67 to the provider's care. Review of the provider's documentation revealed that resident 67's admission medications did not arrive at the facility until 6/18/26 at 12:03 a.m. There was no documentation that resident 67 received her 6/17/26 dose of antibiotic. On 6/18/26, RN KK documented in resident 67's nurse progress notes, "unable to flush PICC line after infusion of IV antibiotic. Antibiotic infused without difficulty. Call placed to [redacted name] Infectious disease for further direction." On 6/19/26 a RN S "Resident on IV antibiotic. PICC line unable to be flushed due to being plugged. No return call back from [redacted name] ID [infectious disease]." "States she [resident 67] does not want to be here." Resident 67 complained of a "burning" sensation when her mouth was dry. An appointment was made 6/22/26 for resident 67 to be evaluated	F0726	Audit results will be compiled by the Director of Nursing and presented monthly for three months to the Quality Assurance and Performance Improvement (QAPI) Committee, which includes the Administrator, Director of Nursing, Medical Director, and department managers. 4. 9/21/2026	

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F0726 SS = D	Continued from page 45 for the "burning" sensation by a medical professional. There were no further documented attempts to contact resident 67's physician regarding her PICC line being obstructed. 2. Interview and review of resident 67's EMR on 8/27/26 at 2:21 p.m. with RN KK, RN/regional director C, and administrator A regarding resident 67's antibiotic medication revealed that RN KK stated that when the lumen (a hollow space inside a tube-like structure or medical device) of the PICC line did not flush after administering the antibiotic, she called an infectious disease doctor and left a message. That doctor did not return her phone call. She reported to the evening shift nurse that the lumen would not flush. RN KK indicated that when the infectious disease doctor did not respond to her message, she should have called the previous DON CC or a nurse case manager regarding care of the obstructed lumen. She stated she did not know if the provider's PICC line policy would explain how to care for the lumen, as she was not familiar with the policy. RN KK confirmed that resident 67's MAR included documentation that on the 6/19/26, 6/20/26, and 6/21/26, a different nurse administered the antibiotic through the PICC line. The MAR included that Ceftriaxone 2000 IM was also administered. RN KK indicated that the provider seldom admitted a resident who had a PICC line. She was unable to remember if she had annual education regarding IV access or PICC lines. 3. Interview with previous contracted travel RN MM on 8/27/26 at 6:14 p.m. verified that she administered resident 67's IV antibiotic intravenously via the PICC line, as there were two lumens and one was obstructed. She stated that she was able to flush one side of the lumen attached to the PICC line after she put new caps on the PICC line and was able to flush that same lumen after administering the antibiotic. 4. Interview on 8/28/26 at 11:30 a.m. with administrator A revealed there were no documented PICC line or IV care competencies for RN KK. 5. Interview and review of resident 67's EMR on 8/28/26 at 11:41 a.m. with RN X regarding resident 67's antibiotic administration revealed that on 6/21/26 she attempted to administer the antibiotic through her PICC line. She stated she tried both lumens in the PICC line, and both were occluded.	F0726		

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F0726 SS = D	Continued from page 46 She contacted resident 67's physician and obtained an order to have the antibiotic administered IM. She confirmed resident 67's MAR documentation indicated she had received the antibiotic twice on 6/21/26 and should have received it once. RN X indicated she did not have much experience with the care of PICC lines. RN X stated, "[Resident 67] told me she didn't think the nursing staff was taking good care of her and she wanted to go home." 6. Review of the provider's Maintaining Patency of Peripheral and Central Vascular Access Devices IV Flush policy revealed: "Vascular access devices are aspirated for blood return and flushed prior to each infusion to assess catheter function and prevent complications. Vascular access devices are flushed after each infusion to clear the infused medication from the catheter lumen." "Each lumen of a multi-lumen catheter must be flushed individually." "To succeed with saline flushing, a needleless connector with an anti-reflux design must be placed on the hub of EVERY lumen of EVERY vascular access device/catheter." "Never inject against resistance. A pulsatile flushing technique of short boluses interrupted by brief pauses may be effective in better catheter clearance." "Repeat for each individual lumen as needed." There was no indication in the provider's policy of the process for removing the obstruction of the PICC line. B. Based on observation, record review, interview, and policy review, the provider failed to ensure controlled substances were secured and accounted for by RN S and certified medication aide (CMA) V, regarding two of two observed residents (11 and 25) whose controlled medications were missing. Findings include: 1. Observation and review of the provider's Controlled Substance Book on 8/27/26 at 1:59 p.m. with contracted travel licensed practical nurse (LPN) T revealed nurses and certified medication aides (CMAs) reconciled scheduled and as-needed controlled medications (the process of comparing the medical record against an inventory of medication to prevent errors such as omissions, duplications, or incorrect dosages) at the beginning and end of the day, evening, and night shifts. After	F0726		

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(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
F0726 SS = D	Continued from page 47 verifying the available quantity of the controlled medications, the nurses and CMAs signed the provider's Controlled Substance Book to accept accountability of the medications during their shift. Each medication cart (A and B) had two signature books, one for scheduled medications and one for as-needed medications. All four signature books were missing multiple staff signatures during the months of June, July, and August 2026. Contracted travel LPN T stated that the process of signing the Controlled Substance Book varied among the staff, depending on preference. "Some staff sign it at the beginning of their shift, but I like to sign it at the end of my shift to make sure everything is correct." She did not know who was responsible for ensuring that the staff signed the book on each shift. 2. Observation, review of the Controlled Substance Book, and EMR review on 8/27/26 at 4:41 p.m. with CMA V revealed that the medication count for resident 11's as-needed Lorazepam (a medication used to treat anxiety) was off by one pill. According to the Controlled Substance Book, there should have been 16 Lorazepam 0.5 milligram (mg) pills in the resident's medication card, but there were only 15. The medication count for resident 25's scheduled Hydrocodone Acetaminophen (a medication used to manage moderate to severe pain) was off by one pill. According to the Controlled Substance Book, there should have been 29 Hydrocodone Acetaminophen 5-325 mg pills in the resident's medication card, but there were only 28. 3. Interview on 8/27/26 at 5:14 p.m. with CMA V revealed that if the medication counts were off, she would search the entire medication cart to see if any pills came loose from the medication card. She did this and did not find resident 11 and 25's missing pills. She stated she would tell the charge nurse or director of nursing (DON) B about the discrepancy. CMA V said that when counting medications, she would say the number of counted pills in the medication card while the other nurse or CMA verified the number in the Controlled Substance Book. She said she had verified the medication count with registered nurse (RN) S at the start of her shift that day (8/27/26). "To my knowledge, it was	F0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2026

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F0726 SS = D	Continued from page 48 accurate this morning." 4. Interview and EMR review on 8/27/26 at 6:06 p.m. with DON B revealed she had identified a clerical error that resulted in the medication count discrepancy for resident 25's Hydrocodone Acetaminophen. The error occurred on 8/26/26 at 5:00 p.m. when RN S administered a Hydrocodone Acetaminophen to resident 25, documented it in the resident's EMR, but did not document it in the Controlled Substance Book. 5. Interview and EMR review on 8/28/26 at 9:30 a.m. with DON B revealed she had identified a second clerical error that resulted in the medication count discrepancy for resident 11's Lorazepam. The error occurred on 8/27/26 at 8:00 a.m. when CMA V administered a Lorazepam to resident 11, documented it in the resident's EMR, but did not document it in the Controlled Substance Book. DON B felt that if she did not investigate the medication count discrepancy for these two medications, the clerical errors would have eventually been noticed by the evening shift staff. She stated that it was a frustrating system and that incorrect medication counts have happened one other time that she knew of. There were 10 nursing staff members who attended an in-service education meeting by PharMerica (pharmacy provider) on 8/20/26 to learn about safe medication administration and controlled substance reconciliation processes. Aside from the pharmacy in-service meeting, DON B said she did not perform competency testing for controlled substance reconciliation. She felt the process could improve if both nurses have eyes on the number of pills in the resident's medication pack and the count documented in the Controlled Substance Book. "They need to take accountability of both numbers." DON B said the resident care manager is responsible for auditing the Controlled Substance Book to ensure the staff are correctly counting medications and signing the book each shift. The facility did not currently have anyone hired for that role, so DON B assumed those responsibilities. 6. Review of the provider's January 2026 Medication	F0726		

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F0726 SS = D	Continued from page 49 Administration Policy revealed that each medication administration is documented in the resident's EMR or medication administration record (MAR) (a log used to track all the medications given to a patient) by the person administering the medication. The staff's initials on each resident's MAR were verified with a full signature in the space provided in the Controlled Substance Book or on the nursing care center's master employee signature log. C. Based on observation, interview, record review, and policy review, the provider failed to ensure a medication error rate of less than 5 percent. The facility failed to prevent a medication error involving two inhalers (a small, handheld medical device that delivers medication directly into your lungs when you breathe) for one of one observed resident (55) when contracted travel licensed practical nurse (LPN) T and certified medication aide (CMA) V left the inhalers on a dining room table for the resident to self-administer. Resident 55 did not have a physician's order to self-administer either inhaler. This practice resulted in a medication error rate of 6.25 percent. Findings include: 1. Observation and interview on 8/27/26 at 7:50 a.m. with contracted travel LPN T revealed she brought a cup of medication and two inhalers to resident 55 as he sat in his wheelchair eating breakfast at a dining room table. She placed the cup of medication and two inhalers on the table beside resident 55 and returned to the medication cart approximately 20 feet away. Contracted travel LPN T stated resident 55 had a rigid routine for how and when he preferred to take his medication, saying, "we don't hover over him." She said he knew to take his medication after he finished breakfast. She performed hand hygiene and proceeded to administer medications to other residents in the dining room. At 7:57 a.m., after resident 55 finished eating breakfast, he took one puff from each inhaler and swallowed the tablets in the medication cup, then self-propelled his wheelchair away from the table and left the dining room, leaving the two inhalers on the table.	F0726		

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F0726 SS = D	Continued from page 50 At 7:59 a.m., contracted travel LPN T administered medication to residents on the north side of the dining room with her back turned to the table where resident 55's two inhalers remained. Approximately 12 residents were eating breakfast in the dining room, and several residents passed by the table with the two inhalers. At 8:14 a.m., contracted travel LPN T administered medications to a resident sitting adjacent to the table with resident 55's inhalers. At 8:17 a.m., she collected resident 55's two inhalers and returned them to the medication cart. 2. Review of resident 55's electronic medical record (EMR) revealed he had a diagnosis of chronic obstructive pulmonary disease (COPD) (a progressive, long-term lung disease that makes it difficult to breathe). He had a 7/22/26 physician's order for Breo Ellipta Inhalation Aerosol Powder (a brand-name prescription dry powder inhaler used for long-term maintenance treatment of asthma and COPD), inhale one puff orally once daily, and a 5/1/25 physician's order for Combivent Respimat Aerosol Solution (a prescription inhalation spray that helps open the airways in the lungs for adults with COPD), inhale two puffs orally once daily. He had physician's orders to self-administer Icy Hot (a topical pain cream) and AutoShield Duo (an insulin pen), but he did not have orders to self-administer any other medications, including the two inhalers. 3. Interview with contracted travel LPN T revealed she normally picked up resident 55's inhalers as soon as he left the dining room, but she was behind schedule today. 4. Observation on 8/28/26 at 7:50 a.m. revealed resident 55 was sitting in his wheelchair eating breakfast at a dining room table. CMA V was administering medications to other residents. At 8:41 a.m., resident 55's two inhalers were sitting on his dining room table while he was not present in the dining room. CMA V was assisting resident 31 and her back was to the inhalers. Eight residents were eating breakfast in the dining room.	F0726		

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F0726 SS = D	Continued from page 51 At 8:43 a.m., director of nursing (DON) B walked past the table, collected the two inhalers, and gave them to CMA V. 5. Interview on 8/28/26 at 8:44 a.m. with DON B revealed she expected the nurses and med aides to wait next to resident 55 while he used the inhalers, then collect the inhalers and return them to the medication cart. She stated they could collect an inhaler later for residents with a physician's order to self-administer their inhaler, but since resident 55 did not have such an order, she felt it was unacceptable to observe his two inhalers sitting unattended on his dining room table. 6. Review of the provider's January 2026 Medication Storage Policy revealed medications were to be stored properly to maintain their integrity and support safe drug administration. Medication carts, rooms, cabinets, and medication supplies were to remain locked when not in use or when not attended by authorized personnel. 7. Review of the provider's January 2026 Medication Administration Policy revealed residents were allowed to self-administer medications only when specifically authorized by the prescriber, the nursing home's interdisciplinary team (IDT), and in accordance with facility procedures for self-administration.	F0726		
F0732 SS = D	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F0732	1. Daily Nurse Staffing information has been posted in a location where residents and visitors can easily view it and it includes the resident census. 2. Daily Nurse staffing information will be posted on first and second floor in a location where residents and visitors can easily view it and it includes the resident census. All staff have been educated on where the Nuse staffing information needs to be posted, that 2 copies need to be made so it can be posted in the designated area on first and second floor, and that the Daily Nurse staffing information must always include resident census. Night nurses were educated where to find resident census and that this information must be included on the Daily Nurse staffing information form by the DON/designee by 9/21/2026. Those not in attendance due to illness, vacation, and leave of casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift.	9/21/26

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F0732 SS = D	Continued from page 52 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of the daily nurse staffing posting form, and policy review, the provider failed to ensure the daily nurse staffing information form was posted in a location where residents and visitors could easily view it and that it included the resident census. Findings include: 1. Observation from 8/27/26 at 9:43 a.m. of the daily	F0732	3. The Administrator of designee will audit the Daily Nuse Staffing information sheets 3 times a week for 2 weeks, twice a week for 2 weeks, then weekly for 2 months and monthly for 2 months to ensure postings are in designated areas, are correct and resident census is on the form. The QAPI Committee will review audit findings, identify trends, evaluate the effectiveness of corrective actions, and implement additional corrective measures and staff education as needed to maintain compliance. Audit results will be compiled by the Director of Nursing and presented monthly for three months to the Quality Assurance and Performance Improvement (QAPI) Committee, which includes the Administrator, Director of Nursing, Medical Director, and department managers. 4. 9/21/2026	

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F0732 SS = D	Continued from page 53 nurse staffing posting on the second floor of the building revealed it was located above eye level behind the nurse's desk and did not include the daily census. 2. Interview and review of the daily staffing information form on 8/27/26 at 9:46 a.m. with director of nursing (DON) B revealed she was not aware there was a daily nurse staffing posting form. She thought business office manager (BOM) F completed the form. 3. Observation, interview, and review of the daily nurse staffing information form posted on 8/27/26 at 1:10 p.m. with BOM F revealed that the night shift nurse completed the daily nurse staffing information form. BOM F keeps a copy of the completed forms in her office. There was a space on the form to document the resident census. She confirmed that none of those forms had the resident census documented on them. She thought the form was posted at the nurses' station by the residents' sign-out book, so they would be able to see it easily. After reviewing where the form was located behind the nurses' desk, she agreed it would be difficult for residents and visitors to see the information on the nursing staff daily posting. She stated the form must have been recently moved. 4. Interview on 8/27/26 at 1:54 p.m. with administrator A revealed the daily nurse staffing posting form was previously taped to a post next to the nurses' station at a level that someone in a wheelchair would be able to see. She had moved it from the post to the wall behind the nurses' desk. She confirmed residents and visitors would not be able to easily view the form in its current location. Administrator A indicated there was no daily nurse staffing information form located on the first floor. She had not thought about posting one there. 5. Review of the provider's July 2012 Daily Nurse Staffing Information policy revealed "A designated individual records the following information on the Daily Nurse Staffing Information Form and posts daily: ...d. Resident census at the beginning of each shift." "Posting Requirements a. The Center posts the nurse staffing data on a daily basis at the beginning of e3ach shift [.] b. Data is posted as follows: ...In a prominate place readily accessible to residents and visitors.	F0732		

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F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure a medication error rate of less than 5 percent. The facility failed to prevent a medication error involving two inhalers (a small, handheld medical device that delivers medication directly into your lungs when you breathe) for one of one observed resident (55) when contracted travel licensed practical nurse (LPN) T and certified medication aide (CMA) V left the inhalers on a dining room table for the resident to self-administer. Resident 55 did not have a physician's order to self-administer either inhaler. This practice resulted in a medication error rate of 6.25 percent. Findings include: 1. Observation and interview on 8/27/26 at 7:50 a.m. with contracted travel LPN T revealed she brought a cup of medication and two inhalers to resident 55 as he sat in his wheelchair eating breakfast at a dining room table. She placed the cup of medication and two inhalers on the table beside resident 55 and returned to the medication cart approximately 20 feet away. Contracted travel LPN T stated resident 55 had a rigid routine for how and when he preferred to take his medication, saying, "we don't hover over him." She said he knew to take his medication after he finished breakfast. She performed hand hygiene and proceeded to administer medications to other residents in the dining room. At 7:57 a.m., after resident 55 finished eating breakfast, he took one puff from each inhaler and swallowed the tablets in the medication cup, then self-propelled his wheelchair away from the table and left the dining room, leaving the two inhalers on the table.	F0759	1. Resident 55 has been deemed safe to self-administer his two inhalers at the dining room table after meals and a physician order has been obtained. Resident preference for administering his inhalers after meals at the dining room table has been care planned to reflect his wishes and preferences. All other residents that self-administer medications are a risk for not having their evaluation completed timely, having a provider order allowing self-administration, or self-administration of medications care planned to validate their preferences. 2. Review of all residents that have been deemed safe to administer medications per self or per self after set up by a nurse have been reviewed and current assessments reflect they are safe, physician orders have been reviewed and obtained as necessary and care plans have been updated to reflect the desire and preferences for resident who are determined safe to self-administer medications. Self-Administration assessments must be completed upon admission if the resident expresses desire to self-administer any or all medications, quarterly, significant change and annually until deemed unsafe to no longer be able to administer medications. Charge nurses and RCM's that are completing the self-administration of medications have been educated on when evaluations need to be completed, that a physician's order must be obtained and follow each medication they have been deemed safe to administer. All nurses, CMA's and RCM's have been educated that medications that do not have an order for self-administration cannot be left with the resident to take without supervision during the entire medication pass or while the medications are in the reach of the resident. All education was completed by the DON/Designee by 9/21/2026. Those not in attendance due to illness, vacation, and leave of casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. 3. The DON/designee will audit residents with Self-Administration orders to ensure they have a current evaluation completed or that they are completed per the schedule, Physician orders are current and up to date for self-administration, and the care plan reflects the ability to self-administer medications and the resident preferences. The DON/Designee will perform 3 random observations during meal time to ensure that medications that are left in the presence of a resident have been deemed safe to self-administer medications. Audits will be conducted weekly for 4 weeks, Bi-monthly for 1 month, and monthly for 3 months. Audit results will be compiled by the Director of Nursing and presented monthly for three months to the Quality Assurance and Performance Improvement (QAPI) Committee, which includes the Administrator, Director of Nursing, Medical Director, and department managers.	9/21/26

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F0759 SS = D	Continued from page 55 At 7:59 a.m., contracted travel LPN T administered medication to residents on the north side of the dining room with her back turned to the table where resident 55's two inhalers remained. Approximately 12 residents were eating breakfast in the dining room, and several residents passed by the table with the two inhalers. At 8:14 a.m., contracted travel LPN T administered medications to a resident sitting adjacent to the table with resident 55's inhalers. At 8:17 a.m., she collected resident 55's two inhalers and returned them to the medication cart. 2. Review of resident 55's electronic medical record (EMR) revealed he had a diagnosis of chronic obstructive pulmonary disease (COPD) (a progressive, long-term lung disease that makes it difficult to breathe). He had a 7/22/26 physician's order for Breo Ellipta Inhalation Aerosol Powder (a brand-name prescription dry powder inhaler used for long-term maintenance treatment of asthma and COPD), inhale one puff orally once daily, and a 5/1/25 physician's order for Combivent Respimat Aerosol Solution (a prescription inhalation spray that helps open the airways in the lungs for adults with COPD), inhale two puffs orally once daily. He had physician's orders to self-administer Icy Hot (a topical pain cream) and AutoShield Duo (an insulin pen), but he did not have orders to self-administer any other medications, including the two inhalers. 3. Interview with contracted travel LPN T revealed she normally picked up resident 55's inhalers as soon as he left the dining room, but she was behind schedule today. 4. Observation on 8/28/26 at 7:50 a.m. revealed resident 55 was sitting in his wheelchair eating breakfast at a dining room table. CMA V was administering medications to other residents. At 8:41 a.m., resident 55's two inhalers were sitting on his dining room table while he was not present in the dining room. CMA V was assisting resident 31 and her back was to the inhalers. Eight residents were eating breakfast in the dining room.	F0759	4. 9/21/2026	

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F0759 SS = D	Continued from page 56 At 8:43 a.m., director of nursing (DON) B walked past the table, collected the two inhalers, and gave them to CMA V. 5. Interview on 8/28/26 at 8:44 a.m. with DON B revealed she expected the nurses and med aides to wait next to resident 55 while he used the inhalers, then collect the inhalers and return them to the medication cart. She stated they could collect an inhaler later for residents with a physician's order to self-administer their inhaler, but since resident 55 did not have such an order, she felt it was unacceptable to observe his two inhalers sitting unattended on his dining room table. 6. Review of the provider's January 2026 Medication Storage Policy revealed medications were to be stored properly to maintain their integrity and support safe drug administration. Medication carts, rooms, cabinets, and medication supplies were to remain locked when not in use or when not attended by authorized personnel. 7. Review of the provider's January 2026 Medication Administration Policy revealed residents were allowed to self-administer medications only when specifically authorized by the prescriber, the nursing home's interdisciplinary team (IDT), and in accordance with facility procedures for self-administration.	F0759		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of one discharged resident (67) received her physician-prescribed antibiotic intravenously (IV) (within a vein) as ordered for her right knee infection. Findings include:	F0760	1. Resident 67 no longer is a resident at the facility. All other residents receiving IV medication are at risk for not receiving their antibiotics as ordered by the physician for their infection. 2. All licensed nurses have been educated on the importance of a resident receiving IV antibiotics per provider orders, what to do if the PICC is unable to be accessed or is not viable to administer the medication and that the provider needs to be contacted immediately to be notified of the circumstances surrounding the missed dose of IV medication. Educated by the DON/designee on 9/21/2026. Those not in attendance due to illness, vacation, and leave of casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. 3. The DON will review admissions and readmission prior to being admitted validating if a PICC will need to be cared for and managed. When a resident resides in the facility with a PICC the DON will complete 3 nurse interviews who are caring for the resident with a PICC	9/21/26

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(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
F0760 SS = D	Continued from page 57 1. Review of resident 67's closed electronic medical record (EMR) revealed she admitted to the facility on 6/17/26. She went to a clinic appointment on 6/22/26 and was admitted to the hospital from that appointment, as she refused to return to the provider's facility. Resident 67's diagnoses included right artificial knee joint, right knee infection, anxiety disorder, depression, history of methicillin resistant staphylococcus aureus infection, right knee streptococcus, group A; cellulitis of right lower limb, type 2 diabetes, sepsis due to anaerobes. Her 6/18/26 Brief Interview of Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. Resident 67's 6/17/26 physician orders included an order for ceftriaxone sodium-dextrose (an antibiotic) intravenous solution to be administered every 24 hours for infection of prosthetic knee joint until 6/23/26. She had a peripherally inserted central line catheter (PICC) (a long, thin, flexible tube used as a long-term IV, that is inserted in a vein in the upper arm and guided through blood vessels until the tip rests in a large central vein near the heart). Resident 67's medication administration record (MAR) included documentation that on the 6/19/26 and 6/20/26 the antibiotic was administered through the PICC line. The MAR included that administration of Ceftriaxone 2000 IM (intramuscular) was also administered on 6/21/26. Resident 67's nurse progress notes indicated that on 6/17/26 resident 67 was admitted to the facility. At 11:37 p.m. her medications had not been delivered, and she did not want to be woken up to take them. She had a wound vac (a device that uses negative pressure remove excess fluid and debris from a wound to promote wound healing) on her right knee. There was a PICC line placed in her left arm. It was noted on 6/18/26 that her medications arrived from the pharmacy at 12:03 a.m. On 6/18/26 a nurse documented "unable to flush PICC line after infusion of IV antibiotic. Antibiotic infused without difficulty. Call placed to [redacted name] Infectious disease for further direction." On 6/19/26, a nurse's progress note included "Resident on IV antibiotic. PICC line unable to be flushed due to being plugged. No return call back from [redacted name] ID [infectious disease]." "States she [resident 67] does not want to be here." Resident 67 complained of a "burning" sensation when her mouth was dry. An appointment was made	F0760	a week while the PICC remains in use, until removed or the resident has been discharged from the facility to ensure trouble shooting, questions, and or concerns have been addressed. Audit results will be compiled by the Director of Nursing and presented monthly for three months to the Quality Assurance and Performance Improvement (QAPI) Committee, which includes the Administrator, Director of Nursing, Medical Director, and department managers. 4. 9/21/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2026

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F0760 SS = D	Continued from page 58 for 6/22/26 for resident 67 to be evaluated for the "burning" sensation by a medical professional. On 6/19/26, there was a wound note for resident 67's right knee in the nurses' progress notes that indicated her right knee was pink, there was swelling present, and her skin was warm and dry. On 6/20/26, a wound note for her right knee indicated there was swelling present, the surrounding tissue of the wound was swollen, and her skin was warm and dry. On 6/21/26, a nurses' progress note indicated, "Resident wants to go to [redacted name] hosp [hospital] for PICC line changed. Writer did call ER [emergency room] dept [department] requesting if resident can go in for PICC changed. Stated they don't. change PICC lines." On 6/21/26, a nurse's progress note indicated, "Per AM treatment nurse. Stated PICC line flushed [flush] not working. IV antibiotics not administer [administered]." The nurse called the emergency room at a different hospital and reported the PICC line was not working. A physician's order for ceftriaxone 2,000 mg [milligram] intramuscular [IM] was obtained via facsimile. The physician's order included a notation of "Reach out to PCP [primary care provider] for ER referral prn [as needed] for malfunctioning [not working] PICC Line". On 6/21/26, a wound note for resident 67's right knee indicated there was swelling and drainage present. Her IM ceftriaxone was administered at 4:30 p.m. On 6/21/26, a facsimile was sent to the clinic indicating resident 67's "PICC [line] not flushing". The certified nurse practitioner responded on 6/22/26 with orders for resident 67 to be discharged to a rehabilitation hospital. On 6/22/26, resident 67 was seen at a clinic related to her evaluation for the "burning" sensation in her mouth. She was discharged to the rehabilitation hospital while she was at that appointment. Resident 67's Discharge Summary Plan of Care Recap of Stay evaluation indicated that she had an IV antibiotic "in place". 2. Interview and review of resident 67's EMR review on 8/27/26 at 2:21 p.m. with registered nurse (RN) KK, RN/regional director C, and administrator A regarding resident 67's antibiotic medication revealed that Resident 67 received her last hospital	F0760		

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F0760 SS = D	Continued from page 59 dose of antibiotic on 6/16/26. When resident 67 admitted to the facility on 6/17/26, her medications, including her physician-prescribed antibiotic, were not available to be administered until midnight on 6/17/26. Resident 67 had asked not to be woken up to take her medications. RN KK stated that when the lumen (a hollow space inside a tube-like structure or medical device) of the PICC line did not flush, she called an infectious disease doctor and left a message. That doctor did not return her phone call. She reported to the evening shift nurse that the lumen would not flush. RN KK indicated that she should have called the previous DON CC or a nurse case manager regarding care of the obstructed lumen. She stated she did not know if the provider's PICC line policy would explain how to care for the lumen, as she was not familiar with the policy. RN KK confirmed that resident 67's MAR included documentation that on the 6/19/26, 6/20/26, and 6/21/26, a different nurse administered the antibiotic through the PICC line. The MAR included that Ceftriaxone 2000 IM was also administered. RN KK indicated that the provider seldom admitted a resident who had a PICC line. She was unable to remember if she had annual education regarding IV access or PICC lines. 3. Interview with previous contracted travel RN MM on 8/27/26 at 6:14 p.m. verified that she administered the IV antibiotic intravenously via the PICC line, as there were two lumens and one was occluded. She stated that she was able to flush one side of the lumen attached to the PICC line after she put new caps on the PICC line and was able to flush that same lumen after administering the antibiotic. 4. Interview on 8/28/26 at 11:30 a.m. with administrator A revealed there were no documented PICC line or IV care competencies for RN KK. 5. Interview and review of resident 67's EMR on 8/28/26 at 11:41 a.m. with RN X regarding resident 67's antibiotic administration revealed that on 6/21/26 she attempted to administer the antibiotic through her PICC line. She stated she tried both lumens in the PICC line, and both were occluded. RN X contacted a physician for an IM order of antibiotic. After receiving the order for ceftriaxone 2,000 mg IM, she administered it and called the emergency room at the hospital as resident 67 wanted to be transferred to the hospital. RN X stated she remembers resident 67 stating she wanted to go	F0760		

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F0760 SS = D	Continued from page 60 home as she did not feel the provider was doing their job. RN X stated she did not want to remove a PICC line as in her training and education, the line went into the heart and should not be removed by someone who does not have "a lot of experience" in PICC line care, and she felt she did not have that experience. Resident 67 was transferred to the hospital on 6/22/26. 6. Review of the provider's Maintaining Patency of Peripheral and Central Vascular Access Devices IV Flush policy revealed: "Vascular access devices are aspirated for blood return and flushed prior to each infusion to assess catheter function and prevent complications. Vascular access devices are flushed after each infusion to clear the infused medication from the catheter lumen." "Each lumen of a multi-lumen catheter must be flushed individually." "To succeed with saline flushing, a needleless connector with an anti-reflux design must be placed on the hub of EVERY lumen of EVERY vascular access device/catheter." "Never inject against resistance. A pulsatile flushing technique of short boluses interrupted by brief pauses may be effective in better catheter clearance." "Repeat for each individual lumen as needed." There was no indication in the provider's policy of the process for removing the obstruction of the PICC line.	F0760		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F0761	1. Insulin and nutritional supplements are being stored at proper temperatures. Three of three medication refrigerators (A, B, and C) are at risk for being out of acceptable temperature ranges between 35 and 40 degrees Farenheit. 2. Medication refridgerator C is being replaced. All other medication refreigerators including refrigerator C continue to have the temperature checked twice a day by the nurse or CMA. All nursing staff have received education by the DON/designee by 9/21/2026 on the importance of checking medication refridgerator temperatures, what the appropriate temperature range is and what to do if out of range. Those not in attendance due to illness, vacation, and leave of casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. 3. DON/designee will audit medication refridgerator log sheets daily Monday through Friday for 4 weeks, three times a week for 2 weeks, twice a week for 2 weeks, then bi-monthly for 3 months. Audit results will be compiled by the Director of Nursing and presented monthly for three months to the Quality Assurance and Performance Improvement (QAPI) Committee, which includes the Administrator, Director of Nursing, Medical Director, and department managers.	9/21/26

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F0761 SS = D	Continued from page 61 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: A. Based on observation, interview, record review, and policy review, the provider failed to ensure that insulin and nutritional supplements were stored at proper temperatures when the staff failed to document daily temperature readings for three of three sampled medication refrigerators (A, B, and C). One of three sampled medication refrigerators (C) did not maintain an acceptable temperature between 35 and 40 degrees Fahrenheit. Findings include: 1. Observation and interview with licensed practical nurse (LPN)/infection preventionist (IP) H on 8/27/26 at 4:20 p.m. revealed that the medication storage room had three small refrigerators that were used to store medications. Refrigerator A had a temperature of 39 degrees Fahrenheit (F) and contained unopened cans of beer with residents' names on them and two stock bottles of Med Pass 2.0 Vanilla (a high-calorie, high-protein nutritional shake designed to be used with medications instead of water or juice for patients at risk for malnutrition). The daily temperature monitoring log sheet taped to the front of the refrigerator revealed temperatures were checked once daily. It indicated the refrigerator was 44 degrees F on 8/9/26; 42 degrees F on 8/11/26; and 42 degrees F on 8/23/26. All other August dates revealed temperatures documented between 35 and 40 degrees F, except 8/13/26 and 8/17/26, which were blank. LPN/IP H said the night shift staff were responsible for documenting the refrigerator temperatures. She stated that appropriate temperature range was between 35 and 40 degrees F and agreed that no temperature was documented for 8/13/26 and 8/17/26 for refrigerator A. She said if the temperature of a medication refrigerator was outside	F0761	4. 9/21/2026	

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F0761 SS = D	Continued from page 62 of the acceptable range, the staff were to notify maintenance director DD or director of nursing (DON) B. She did not know whether the staff had notified anyone when temperatures were documented as 42 and 44 degrees. Refrigerator B revealed it was locked and had a temperature of 40 degrees F. It contained unopened vaccine vials and an emergency insulin kit. The daily temperature monitoring log sheet taped to the front of the refrigerator revealed temperatures were checked once daily and were documented between 35 and 40 degrees F for each August date except 8/11/26, 8/13/26, 8/17/26, and 8/26/26, which were blank. LPN/IP H agreed that no temperature was documented on these four dates. Refrigerator C had a temperature of 50 degrees F and contained unopened vials of insulin and insulin pens with residents' names on them. The daily temperature monitoring log sheet taped to the top of the refrigerator revealed temperatures were checked once daily and were documented as 42 degrees F on 8/14/26, 8/18/26, and 8/20/26. No temperature was documented on 8/13/26, 8/17/26, and 8/26/26. All other August dates had a documented temperature of 40 degrees F. When LPN/IP H opened the refrigerator door, several of the insulin pens fell out and spilled onto the floor. She stated, "It's way too full, that might be why the temperature is so high." She did not know if the staff had notified maintenance director DD or DON B when the temperature was documented as 42 degrees F, and she did not know how long the refrigerator had been at 50 degrees F. At 4:33 p.m., LPN/IP H transferred the insulin to refrigerator B and notified maintenance director DD that medication refrigerator C was reading at 50 degrees F. At 5:15 p.m. director of maintenance DD stated he had fixed refrigerator C and the temperature was "coming down." At 6:01 p.m., medication refrigerator C had a temperature of 44 degrees F. 2. Observation and interview with LPN/IP H on 8/28/26 at 8:33 a.m. revealed refrigerator C was restocked with insulin and had a temperature of 40 degrees F. LPN/IP H said she reminded the staff not to fill the medication refrigerator so full that it would compromise its temperature.	F0761		

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F0761 SS = D	Continued from page 63 3. Interview on 8/28/26 at 10:00 a.m. with DON B revealed she expected the night shift staff to verify the refrigerator temperatures every night and immediately notify maintenance director DD if the temperature was below 35 degrees F or above 40 degrees F. She said that if refrigerator C had a temperature of 50 degrees F for one day, she would have to verify with a pharmacist but believed opened insulin could remain at room temperature for up to 28 days. She was not concerned about the integrity of the insulin in refrigerator C. 4. Copies of the daily temperature monitoring logs for medication refrigerators A, B, and C were requested on 8/27/26 but were not provided. 5. Review of the provider's January 2026 Medication Storage Policy revealed that, "Medications requiring refrigeration are kept in a refrigerator with a thermometer to allow temperature monitoring, and a temperature log or tracking mechanism is maintained to verify that temperatures remain within acceptable limits. Temperatures of refrigerators containing medication should be monitored and recorded at least once daily, the policy read, and twice daily for refrigerators containing vaccines. Insulin should be stored in the refrigerator until opened, and opened insulin should be stored at room temperature." B. Based on observation, interview, and policy review, the provider failed to ensure safe and secure storage of resident medications when contracted travel licensed practical nurse (LPN) II and registered nurse (RN) X left their medication carts unlocked, unattended, and accessible to anyone passing by, and when RN S left a bottle of Acetaminophen (an over-the-counter medicine that relieves mild-to-moderate pain and reduces fever) on top of an unattended medication cart. Findings include: 1. Observation on 8/25/26 at 9:12 a.m. revealed an unlocked medication cart sitting next to the nurse's station outside of the dining room. Contracted travel LPN II was sitting at the nurse's desk writing on a piece of paper. She then stood and walked away from the nurse's station and went into the dining room. At 9:13 a.m. she returned and spoke to	F0761		

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F0761 SS = D	Continued from page 64 certified medication aide (CMA) V at a different medication cart. 2. Interview at 9:15 a.m. with contracted travel LPN II revealed that she was responsible for the unlocked medication cart. She did not know the cart was unlocked. She locked the cart and said she did not normally leave it unlocked and that she had just stepped away to help a resident. 3. Observation on 8/26/26 at 3:03 p.m. revealed an unlocked medication cart sitting next to the nurse's station outside of the dining room. RN X was sitting at the nurse's desk working on a computer. Two staff members and one resident passed by the medication cart, and one resident stood near the nurse's office across the hall from the medication cart. 4. Interview on 8/26/26 at 3:08 p.m. with RN X revealed that she was responsible for the unlocked medication cart. She did not know the cart was unlocked. She walked around the nurse's station and locked the medication cart, apologized, and said she had gotten busy charting and had forgotten to lock it. 5. Observation and medication administration record (MAR) review on 8/26/26 at 3:30 p.m. revealed that RN S pulled a stock bottle of Acetaminophen out of the medication cart located in the east hallway. RN S placed two tablets in a medicine cup for resident 59, replaced the lid on the bottle of Acetaminophen and set the bottle on top of the cart. She then locked the medication cart and took the cup of two tablets to resident 59 in her room. RN S stepped into resident 59's room, gave the medication to resident 59, washed her hands at the sink in the resident's room, then walked back to the medication cart. RN S said, "Oh, I forgot to get her pain rating," then locked the computer screen and walked back to resident 59's room, leaving the bottle of Acetaminophen on the unattended cart. RN S walked to the nurse's station, passing by the bottle of Acetaminophen on the unattended cart, and talked to RN X. At 3:37 p.m., RN S returned to the medication cart, unlocked the computer screen, documented resident 59's pain rating, unlocked the medication cart, and put the bottle of Acetaminophen away. 6. Interview on 8/26/26 at 4:42 p.m. with RN S	F0761		

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F0761 SS = D	Continued from page 65 revealed that she normally would not leave a bottle of Acetaminophen sitting on top of an unattended medication cart, "but I just forgot today." She said she should have locked the Acetaminophen in the cart before taking medication to resident 59. 7. Interview on 8/26/26 at 10:00 a.m. with director of nursing (DON) B revealed that she felt it was unacceptable to leave Acetaminophen or any medication on top of an unattended medication cart. 8. Review of the provider's 1/2026 Medication Administration policy revealed that "during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications when unlocked."	F0761		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F0880	1. Residents 6, 11, 25, 32, 36 and 53 have had no ill effects after having shared equipment used or the failure of proper hand hygiene performed during medication pass. All residents that have the potential for shared equipment to be used between them or of a nurse not performing appropriate hand hygiene during a medication pass or at risk for he development and transmission of communicable diseases and infections. 3. Shared equipment will be cleaned with the Purple Top wipes between each resident use to ensure a safe, sanitary and comfortable environment to prevent the development and transmission of communicable diseases and infections. Proper hand hygiene during administration of medication for residents will be performed by use of Alcohol Based Hand Gel or washing the hands with soap and water. All nurses, CNA's and CMA's have been educated that equipment that is shared between residents must be cleaned prior to using from one resident to the other by using the Purple Top Wipe and following wet time per the manufacturer label. All nurses and CMA's have been educated on proper and appropriate hand hygiene and when to perform between passing medications between residents. All education was completed by the DON/designee by 9/21/2026. Those not in attendance due to illness, vacation, and leave of casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. 3. The DON/designee will observe and audit 3 incidents involving shared equipment, and 3 incidents of proper hand hygiene during resident-to-resident medication passes for 4 weeks, bi-monthly for 1 month and monthly for 4 months. Audit results will be compiled by	9/21/26

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F0880 SS = D	Continued from page 66 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure a safe, sanitary and comfortable environment to prevent the development and transmission of communicable diseases and infections when registered nurse (RN) S neglected to clean shared medical equipment between uses with	F0880	the Director of Nursing and presented monthly for three months to the Quality Assurance and Performance Improvement (QAPI) Committee, which includes the Administrator, Director of Nursing, Medical Director, and department managers. 4. 9/21/2026	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 67 four of four observed residents (6, 25, 32, and 36) and failed to maintain appropriate hand hygiene during the administration of medications to two of two observed residents (11 and 53). Findings include: 1. Observation on 8/26/26 at 3:27 p.m. revealed registered nurse (RN) S standing in the hallway at the east medication cart. She pulled a bottle of eye drops from the medication cart and, without performing hand hygiene or putting on gloves, she administered two eyedrops in resident 11's left eye. RN S then placed the bottle of eye drops in her scrubs pocket, walked into resident 11's room, washed her hands at the sink, and returned to the medication cart where she put the bottle of eye drops away. 2. Observation on 8/26/26 at 4:31 p.m. revealed RN S with the blood pressure machine in the dining room. She took resident 6's blood pressure, placed the blood pressure cuff into the basket on the stand that held the blood pressure machine, and then walked to resident 25 at another dining table. She removed the cuff from the basket and took resident 25's blood pressure, without cleaning the blood pressure cuff or performing hand hygiene. She placed the cuff back into the basket and pushed the blood pressure machine through the building while searching for resident 32, passing through the activities area, dining room, and east hallway. She located resident 32 in the east hallway and took his blood pressure, without cleaning the blood pressure cuff or performing hand hygiene. She then returned the blood pressure machine to the east hall medication cart and documented the blood pressure readings for residents 6, 25, and 32. She did not clean the blood pressure cuff or perform hand hygiene. 3. Interview on 8/26/26 at 4:41 p.m. with RN S revealed that she had "forgotten" to clean the blood pressure cuff and perform hand hygiene after each resident. She stated she should have cleaned the blood pressure cuff after taking each resident's blood pressure. RN S then pulled a disposable wipe from a container of Personal Wipe StayDry Disposable Washcloths, wiped down the blood pressure cuff, and placed the cuff back in the basket on the stand, without wearing gloves or performing hand hygiene after cleaning the cuff.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	**611 EAST 2ND AVE , FLANDREAU, South Dakota, 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
F0880 SS = D	Continued from page 68 4. Observation on 8/26/26 at 4:46 p.m. revealed RN S in resident 36's room, taking her blood pressure. RN S then placed the blood pressure cuff in the basket and took the blood pressure stand to the nurse's station. She pulled a pair of disposable gloves from the medication cart next to the nurse's station, put them on, and pushed the blood pressure stand back to the east hall medication cart. Without cleaning the blood pressure cuff, she removed the gloves and discarded them in the trash bin. She did not perform hand hygiene. She then opened the computer screen and documented resident 53's blood pressure reading. 5. Observation on 8/26/26 at 4:58 p.m. revealed RN S at the dining room medication cart. She took a bottle of eye drops from the cart and, without performing hand hygiene or putting on gloves, she administered one eye drop in each of resident 53's eyes. RN S then prepared a cup containing seven medications and administered them to resident 53. Afterward, she discarded the medicine cup and unlocked the computer screen. She did not perform hand hygiene before preparing medications for another resident. 6. Interview on 8/28/26 at 10:00 a.m. with director of nursing (DON) B revealed she expected the staff to clean blood pressure cuffs between each resident using Super Sani-Cloth Germicide Disposable Wipes and to perform hand hygiene between each medication pass. She stated staff should wear gloves when administering eye drops. 7. Review of the provider's January 2026 Medication Administration Policy revealed the staff were required to wash their hands and apply gloves before administering ophthalmic (relating to the eye) medications, again after administration, and with any resident contact. 8. Review of the provider's June 2017 Medication Administration Quick Reference Guide revealed the staff were required to wash their hands prior to the start of medication pass and between residents. The guide specified that privacy must be maintained during medication administration and read, "No medication is given in the dining room during a meal or activity. ... Eye drops ... are completed in the resident's room or private area. ... Medications of this designation are not administered in front of	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2026

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F0880 SS = D	Continued from page 69 other residents." 9. Review of the provider's March 2025 Standard Precautions Policy revealed staff were required to wash their hands after removing gloves and to clean or reprocess reusable equipment before using it for another resident.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 8/26/26. Riverview Healthcare Center was found in compliance.	E0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE , FLANDREAU, South Dakota, 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
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 8/26/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Riverview Healthcare Center (building 01) was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K321, K351, and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K0321	1.Executive Director educated Maintenance Director on 9/16/26 regarding Life Safety. The process to ensure safe Hazardous Areas are protected by fire barrier having 1-hour fire resistance rating (with ¾ hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 29.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or filed applied protective plates that do not exceed 48 inches from the bottom of the door. 2.Maintenance Director repaired corridor door to the storage room to ensure proper closure and that the door would latch with the operation of the closure on 9/16/26. As of 9/21/26 a new door with closure has been ordered, and the facility is currently waiting for shipping, assembly and installation of the door. 3. Executive Director or Maintenance Director will audit door closures of the repaired door daily, until the new door is installed until new door is installed. Executive Director will audit door closures throughout the facility once per month. The Executive Director/Maintenance will bring audit results to the monthly QAPI meeting. The committee will review the audits and make recommendations to continue audits or to discontinue the audit process and to continue to monitor. 4.2. Date of Compliance 09/21/26	9/21/26

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	9/25/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING **01 - MAIN BUILD...** B. WING	**08/26/2026**

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

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K0321 SS = D Bldg. 01	Continued from page 1 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain one randomly observed hazardous are (lower-level storage room) as required. Findings Include: 1. Observation and testing on 8/26/26 at 1:50 p.m. revealed the lower-level storage room was over 100 square feet and contained several combustible items. Testing of the corridor door to that room revealed it would not close and latch with the operation of the closer. Further observation at that same time revealed that door had previously been modified and it was striking the door frame opposite the hinge side. That door frame was swollen due to it rusting significantly at the bottom where it meets the floor. Interview with the maintenance director at the time of the observations confirmed those findings.	K0321		
K0351 SS = D Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.	K0351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE , FLANDREAU, South Dakota, 57028

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K0351 SS = D Bldg. 01	Continued from page 2 In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to ensure one random location (elevator equipment room) was protected by an approved automatic sprinkler system. Findings include: 1. Observation on 8/26/26 at 11:45 a.m. revealed the facility had created a new elevator equipment room for the replacement elevator system. Further observation at that same time revealed that the elevator equipment room was not provided with any sprinkler heads. Sprinkler heads are required in every room of the facility to maintain full automatic fire sprinkler system coverage in accordance with NFPA 13 (1.4, 1.4.2, 4.1, 8.1) Basic Requirements, and (8.1.1{1}). Interview with the maintenance director at that same time confirmed those findings. He believed the installation contractor had ensured all code requirements were met and was surprised that room was not provided with automatic fire sprinkler system coverage.	K0351	1. Executive Director educated Maintenance Director on 9/16/26 regarding the construction requirements with approved automatic sprinkler system in accordance with NFLPA 13. The standards of installation of Sprinkler Systems. Spinkler heads are required in every room of the facility to maintain fully automatic fire sprinkler coverage in accordance to NFPA 13 (1.4., 1.4.2, 4.1, 8.1) . The basic requirements, and (8.1.1). 2.Maintenance Director notified Building Sprinkler Company on 8/27/2026 to install an automatic fire sprinkler head system in the new elevator equipment room. Building Sprinkler installed a new sprinkler head on 9/17/26 to meet the NFPA Basic Requirements (8.1.1), for Standard Installation of Sprinkler Systems in all rooms in a facility. 3.The Executive Director and Maintenance Director will review any new projects to ensure compliance with Life Safety NFPA 13 regulations. The audit will be once a month x3 months for any new construction projects. The Executive Director or Maintenance Director will bring the audits to the monthly QAPI meeting. The committee will review the audits and make recommendations to continue to audit or to discontinue the audit process and continue to monitor. 4.Date of Compliance 9/21/26.	9/21/26
K0712 SS = D Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **08/26/2026**

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

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K0712 SS = D Bldg. 01	Continued from page 3 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedure (evacuating affected areas). Findings include: 1. Observation on 8/25/26 beginning at 2:49 p.m. revealed a drill for a simulated fire in room 110 was being conducted. Further observation at that same time revealed the certified nursing assistant (CNA) responding to the activated nurse call light needed prompting to initiate the response to the simulated fire. The maintenance director running the fire drill had to walk the responding CNA through parts of the R.A.C.E. (Rescue, Alarm, Confine/Contain, and Evacuate) steps prior to the CNA taking any action. Through the entire drill process the resident in room 110 was never removed from the affected room. Interview with the maintenance director immediately after the fire drill confirmed those findings. He stated he believed they did not pass the drill.	K0712	1.Executive Director educated Maintenance Director on 9/16/26 that fire drills are to be held at various times and with different conditions once per month rotating shifts every quarter. Staff are to be educated on the simulated emergency fire conditions per NPFA 101. 2.Executive Director or Maintenance Director will execute monthly fire drills and will monitor staff's response time to monthly fire drills to ensure education and drill meet compliance. All staff were educated by Evergreens Education Portal (SNF IQ) with the review of Fire Drills and R.A.C.E. (Rescue, Alarm, Confine/Contain, and Evacuate) along with printed attendance certificates. Staff are educated on hire and annually thereafter 3.The Maintenance Director will audit employee response time and protocol for emergency fire drills once a month x3 months. The Executive Director or Maintenance Director will bring audit results to the monthly QAPI meeting. The committee will review the audits and make recommendations to continue auditing or to discontinue the audit process and continue to monitor. 4.Date of Compliance 9/21/26.	9/21/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING **02 - 1989 ADDIT...** B. WING	**08/26/2026**

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

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K0000 Bldg. 02	INITIAL COMMENTS A recertification survey was conducted on 8/26/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Riverview Healthcare Center (Building 02) was found in compliance.	K0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Adminstrator	9/25/26

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10620	A. BUILDING: _____ B. WING _____	08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	611 E 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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/25/26 through 8/28/26. Riverview Healthcare Center was found not in compliance with the following requirements: S206, S210, S236, and S240.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel	S 206	1) Corrective Action review noted that the contracted employee L, M, and employee #2 could not complete the orientation training within 30 days of their hire date. 2) Human Resources/Designee will notify new employees to complete their Orientation Education training within 30 days of hire date. Current employees will be assigned the completion of Annual Education training. The scheduled All Staff Inservice will be held on 9/21/2026 to review the Orientation Program and the Annual Education Requirements to meet the SD 44.73 requirements. Facility requirements are to utilize Evergreen's SNF IQ module for educational purposes to assign all new personnel with Orientation Education and current employees for ongoing Annual Education training and any other educational need throughout the year to meet requirements. 3) Human Resources/Designee will complete audits on new employee files to complete their formal Orientation Program. Along with current employee files for Annual Education Program to meet requirements SD 44.73. Audits will be completed weekly x4 weeks, bimonthly x1 month, and then monthly x3 months. Results of the audits on the Orientation Program and the Education Program will be presented at the monthly QAPI meeting. The committee will review and make recommendations. 4) Compliance Date 9/21/2026	9/21/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 09/23/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10620	A. BUILDING: _____ B. WING _____	08/28/2026

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S 206	Continued From page 1 education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review and interview, the provider failed to ensure two of two reviewed contracted travel employees (L and M), and one of one reviewed employee (Z) completed orientation training within 30 days of their hire date, and three of three reviewed employees (N, O, and K) completed the annual training. Findings include: 1.Review of contracted travel employee L's employee record revealed she was hired on 6/21/26 as a registered nurse (RN). She did not complete the required orientation training within 30 days of her hire date regarding the topics of fire prevention and response, emergency preparedness, proper restraint use, resident rights, mandatory reporting, incidents and diseases, dining assistance, nutritional risks, and hydration. 2. Review of contracted travel employee M's record revealed she was hired on 11/28/25 as a certified nursing assistant (CNA) . She did not complete the required orientation training within 30 days of her hire date regarding the topics of proper restraint use, resident rights, care of residents with unique needs, mandatory reporting, incidents and diseases, dining assistance, nutritional risks, and hydration. 3. Review of employee Z's record revealed she was hired on 2/18/26 as an activity assistant. She did not complete the required orientation training within 30 days of her hire date regarding the topics of proper restraint use, advance directives,	S 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10620	A. BUILDING: _____ B. WING _____	08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 206	Continued From page 2 dining assistance, nutritional risks, and hydration. 4. Review of employee N's record revealed she was hired on 4/16/18 as an RN. She did not complete the required annual training regarding the topics of fire prevention and response, emergency preparedness, infection prevention and control, accident prevention and safety procedures, proper restraint use, resident rights, confidentiality of resident information, care of residents with unique needs, abuse and neglect, mandatory reporting, advance directives, incidents and diseases, dining assistance, nutritional risks, and hydration. 5. Review of employee O's record revealed she was hired on 11/4/10 as a CNA. She did not complete the required annual training regarding the topics of accident prevention and safety procedures, proper restraint use, mandatory reporting, incidents and diseases, dining assistance, nutritional risks, hydration, and advance directives. 6. Review of employee K's record revealed she was hired on 8/29/18 as the social service director (SSD). She did not complete the required annual training regarding the topics of accident prevention and safety, mandatory reporting, incidents and diseases, dining assistance, nutrition, hydration, and advance directives. 7. Interview on 8/27/26 at 8:09 a.m. with business office manager (BOM) F regarding staff training revealed she was also the temporary human resources and medical records personnel. She indicated there was a packet of orientation materials for new contracted travel staff, which included orientation training. This packet was given to the nurse on duty to review with the	S 206		

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	10620	A. BUILDING: _____ B. WING _____	08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	611 E 2ND AVE FLANDREAU, SD 57028

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S 206	Continued From page 3 contracted travel staff on their first day of employment. She indicated the department managers did not always document that the training was completed. 8. Interview on 8/27/26 at 11:27 a.m. with BOM F regarding staff training revealed the provider used a combination of online education and in-services to train their staff. Most of the training was assigned to employees by the provider's corporate office. She stated that since September 2025, she was responsible for assigning the state-specific education, as there was no human resources employee. She confirmed she did not assign any of that education. She was also responsible to monitor if the employees had completed the assigned education. 9. Interview on 8/27/26 at 6:13 p.m. with RN/regional director C and regional vice president of operations D regarding staff orientation and annual training revealed there was no staff training policy. RVPO D stated they use the state regulation as guidance. 10. Interview on 8/28/26 at 1:41 p.m. with BOM F regarding the staff education and training revealed the staff were automatically assigned the orientation training when they were hired. The annual education was assigned by the corporate office. Administrator A and DON B could add additional courses for the staff to complete. She agreed the orientation education should have been assigned and completed within 30 days for employees L, M, and Z. The annual education should have been assigned and completed for employees N, O, and K.	S 206		

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S 210	Continued From page 4	S 210		
S 210	44:73:04:06 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. Before assignment to duties or within fourteen days after employment, a licensed health professional must evaluate all personnel to ensure no personnel is infected with any reportable communicable disease that poses a threat to others. The evaluation must include an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease that may endanger the health of residents, and fellow personnel may not return to duty until the personnel is determined by a physician, physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review and interview, the provider failed to ensure one of two reviewed contracted travel employees (M) had received a health evaluation upon hire. Findings include: 1. Review of contracted travel employee M's employee record revealed she was hired on 11/28/25 as a certified nursing assistant (CNA). There was no documented employee health evaluation completed. 2. Interview on 8/27/26 at 1:08 p.m. with business	S 210	1) Corrective Action review noted that Employee F did not have a complete health evaluation that was to be completed by a nurse. A facility nurse was responsible for the completion of new employee evaluations to ensure that the employee's health evaluations/assessments are completed. 2) Human Resources/Designee will designate a nurse to provide a Health Assessment for new employees. This includes the evaluation of previous vaccinations and skin tests that were documented prior to working on the floor. The scheduled All Staff Inservice will be held on 9/21/2026 to review the Personnel Health Program to meet SD44.73 requirements of all personnel to be evaluated to protect resident safety. The facility requirements are to utilize Evergreen's SNF IQ module for educational purposes to assign all personnel on Annual Education requirements along with any other education practices needed throughout the year to meet requirements. 3) Human Resources/Designee will complete audits on the Personel Health Program weekly x4 weeks, bimonthly x1 month, and then monthly x3 months. Results of the Personnel Health program audits will be presented at the monthly QAPI meeting. The committee will review and make recommendations. 4) Compliance Date 9/21/2026	9/21/26

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S 210	Continued From page 5 office manager (BOM) F regarding employee health evaluations revealed that licensed practical nurse (LPN)/infection preventionist (IP) H was responsible for ensuring the new employee health evaluations were completed. 3. Interview on 8/27/26 at 1:45 p.m. with administrator A regarding employee health evaluations revealed that she knew they were completed when a new employee was hired. She stated that contracted travel staff should have had them completed by their travel agency. 4. Interview on 8/27/26 at 2:00 p.m. with LPN/IP H revealed she was not responsible for completing employee health evaluations. A registered nurse completed them. She indicated the facility did not have a tracking process to ensure the health evaluations were completed. LPN/IP H stated the health evaluations were to be placed in the employee's personnel files. 5. Interview on 8/27/26 at 6:13 p.m. with registered nurse (RN)/regional director C and regional vice president of operations (RVPO) D regarding a policy for employee health evaluations revealed the facility did not have a policy. RVPO D indicated the provider used the state regulation as their guidance.	S 210		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare personnel or residents are as follows: (1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to	S 236	1) Corrective Action noted that resident #11 had no documented Tuberculin test administered. Employee Z, and AA records noted that there were no documented Tuberculin tests or lab tests. Agency employee L provided one documented Tuberculin test. A facility nurse is responsible for giving a Tuberculin test on request for new hires. No policy on who the specific person is to be responsible for testing all new employees. Agency companies are responsible for providing proof of their employee TB Testing.	9/21/26

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S 236	Continued From page 6 establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of five sampled residents (11), who did not have documentation from the previous facility's tuberculosis (TB) test result, received a TB skin test or a QuantiFERON-TB Gold lab test within twenty-one days of their admission to the facility, two of two employees reviewed (Z and AA)	S 236	2) Human Resources/Designee will review new Personnel Employee Healthcare files for documentation of Tuberculin Screening. The Director of Nurses/Designee will review residents' documentation on their Tuberculin status including any documented testing, or lab results. Including the Two Step Tuberculin Skin test administered 1-3 weeks apart or TB blood test, or chest x-ray. The scheduled All Staff Inservice will be held on 9/21/2026 to review the Orientation Program and the Annual Education requirements for new hires, current employees, and resident documentation requirements. The facility is required to utilize Evergreen's SNF IQ module for educational purposes to assign all personnel to annual education requirements along with any other education practices needed throughout the year to meet requirements. 3) Human Resources/Designee will assess the employee/resident for previous documented vaccinations, lab tests and skin test results. Along with the completion of Tuberculin Screening audits on new healthcare personnel or new residents; audits will be completed weekly x4 weeks, bimonthly x1 month, and then monthly x3 months. Results of the audit from the Tuberculin Screening Requirements will be presented at the monthly QAPI meeting. The committee will review and make recommendations. 4) Compliance Date 9/21/2026	

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S 236	Continued From page 7 received a two-step TB skin test or a QuantiFERON-TB Gold lab test within twenty-one days of their hire date, and one of two contracted travel employees reviewed (L) received a two-step TB skin test or a QuantiFERON-TB Gold lab test within twenty-one days of their hire date to determine if they were a positive TB reactor. Findings include: 1. Review of resident 11's electronic medical record (EMR) revealed she admitted to the facility on 8/3/26. There was no documented TB skin test administered. 2. Review of employee Z's record revealed she was hired on 2/18/26 as an activity aide. There was no documented TB or QuantiFERON-TB Gold lab test in her employee record. 3. Review of employee AA's record revealed she was hired on 5/7/26 as a cook. There was no documented TB or QuantiFERON-TB Gold lab test in her employee record. 4. Review of contracted travel employee L's record revealed she was hired on 6/21/26 as a registered nurse (RN) and had her first TB skin test completed on 5/4/26 by her travel agency, and the result was negative. There was no documentation for a second-step TB skin test. 5. Interview on 8/27/26 at 8:09 a.m. with business office manager (BOM) F revealed the provider did not have contracted travel employee L's completed TB skin test but thought she could get it from her travel agency. 6. Interview on 8/27/26 at 1:15 p.m. with BOM F regarding employee TB skin tests revealed that	S 236		

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S 236	Continued From page 8 LPN/IP H was responsible for ensuring the TB skin tests were completed and documented on the appropriate form. BOM F explained new employees were to receive the first TB skin test on their orientation day, administered by LPN/IP H. Any nurse could read the TB skin test result; however, BOM F indicated it was preferred that LPN/IP H read all TB skin test results to help with tracking their completion. 7. Interview on 8/27/26 at 1:47 p.m. with administrator A regarding employee TB skin tests revealed that all new employees should have a two-step TB skin test completed within 21 days of their hire date. 8. Interview on 8/27/26 at 2:03 p.m. with LPN/IP H and BOM F revealed that LPN/IP H was responsible for administering TB skin tests to new employees. If there was a previously documented TB skin test, it was placed in that employee's file. LPN/IP H indicated that BOM F or social service director (SSD) K were responsible for obtaining the contracted travel employee's TB skin test from their contract travel agency. LPN/IP H indicated that employee Z had a two-step TB skin test completed, and she "might have a copy". BOM F stated she was provided the TB skin tests from one contract travel agency for their travel staff, but she had to request the TB skin tests from three other contract travel agencies. She indicated employee AA was a new employee and should have had a TB skin test completed. BOM F stated, "We never do [administer] TB [tests] to travelers [contracted travel employees]." 9. Interview on 8/27/26 at 5:14 p.m. with RN/regional director C regarding resident 11's TB	S 236		

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S 236	Continued From page 9 skin test revealed the provider had difficulty in contacting resident 11's guardian for consent to immunizations. She thought LPN/IP H may not have understood the facility's TB process. Resident 11 had a chest X-ray related to a mucus plug, and RN/regional director C thought this caused resident 11's delay in receiving the TB skin test when she admitted to the facility. 10. Interview on 8/28/26 at 12:00 p.m. with RN/regional director C regarding the administration of TB skin tests revealed they were to be administered on the first day of orientation for employees and on the day of admission for residents. 11. LPN/IP H did not provide a copy of activity aide Z's TB skin test at the end of the survey. 12. Review of the provider's June 2025 Employee Tuberculosis Screening policy revealed "New Employee Screening" included "Tuberculosis screening for facility personnel is completed prior to commencing work in the facility. TB screening will include: a. Two step TST [Tuberculin Skin Test] Skin Test (administered 1-3 weeks apart) or TB blood test, or chest x-ray. b. Symptom evaluation. c. Individual TB Risk Assessment." "Tuberculosis screening test: two step TST Skin Test (administered 1-3 weeks apart) or TB blood test is completed for those without evidence of completion with negative result, within the preceding 12 months."	S 236		
S 240	44:73:04:12.01 Tuberculosis Education-Healthcare Personnel A facility shall provide yearly education to all healthcare personnel on TB risk factors, the signs	S 240	1) Corrective Action was noted that employee P's health records had no documented annual Tuberculin annual training, risk factors, TB signs and symptoms, and TB infection control policies and procedures for him. Policy requirements that the facility personnel are education on hire and annually thereafter.	9/21/26

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S 240	Continued From page 10 and symptoms of TB, and the TB infection control policies and procedures of the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review, interview, and policy review, the provider failed to ensure one of one reviewed employee (P) received annual tuberculosis (TB) training. Findings include: 1. Review of employee P's record revealed he was hired on 9/27/22 as a dietary aide. There was no documented annual TB training regarding TB signs and symptoms, risk factors, and TB infection control policies and procedures for him. 2. Interview on 8/27/26 at 2:05 p.m. with licensed practical nurse (LPN)/infection preventionist (IP) H revealed there was no annual TB training completed for any employee. 3. Review of the provider's June 2025 Employee Tuberculosis Screening policy revealed, "Education on TB and information about TB exposure risk, is provided to facility personnel on hire and is repeated annually.	S 240	2) Director of Nurses will be the presenter for the All Staff Inservice to be held on 9/21/2026. The discussion will include a review of the Annual Education requirements along with Tuberculosis Education for Healthcare Personnel. The facility is required to utilize Evergreen's SNF IQ module for educational purposes to assign all personnel annual education requirements along with any other education practices needed throughout the year to mee 3) Administrator/Designee will complete audits on Annual Tuberculosis Education-including completing audits once per weekly x4 weeks, bimonthly x1 month, and then monthly x3 months. Results of the audit from the Tuberculosis Education will be presented at the monthly QAPI meeting. The committee will review and make recommendations. 4) Compliance Date 9/21/2026	