STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/25/25 through 2/27/25. Riverview Healthcare Center was found not in compliance with the following requirements: F584, F657, F684, F686, F697, F812, F865, F880 and F908. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/25/25 through 2/27/25. Areas surveyed included quality of care and nursing services related to provision of care and resident safety. Riverview Healthcare Center was found in compliance.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	03/27/25

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

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain a homelike environment that was free from major damages to the walls, floors, ceilings, and door frames. Findings include: 1. Observation on 2/25/25 at 9:48 a.m. of the bathroom shared by residents 6, 9, and 34 revealed: *The ceiling consisted of bare chicken-wire-type metal sheeting. *There was plaster stuck to parts of the chicken wire. *A portion of the chicken wire had been partially cut out from the rest. It was hanging down and was attached by five pieces of wire twisted around it. The pieces of wire looked like bread	F 584		

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F 584	Continued From page 2 bag twist ties. *The piece of chicken wire that was hanging down was directly above the toilet. -If a person were sitting on the toilet and the piece of chicken wire fell, it would have landed on top of that person. *Interview at that time with resident 9 revealed that ceiling had been like that for quite some time, but she could not remember exactly how long. 2. Observations throughout the building on 2/26/25 from 9:04 a.m. to 9:25 a.m. revealed: *The door frame of an emergency exit door was rusted and corroded away at the bottom. -Expanding foam insulation had been sprayed into that corroded area. -Rusty, jagged edges were exposed. *There was no baseboard around the perimeter of a storage room/toilet room on the second floor. What appeared to be particle board or corkboard was exposed. *There were several large paint chunks missing from the walls in the hallway on the second floor. *In the whirlpool tub room on the first floor: -The wallpaper was peeling in several spots. -The caulking around the toilet was stained and had turned brown and black in some areas. -The baseboard heating elements were exposed, potentially causing a hazardous environment. -The floor in the shower had stained to a reddish orange, potentially from rust. *In the therapy gym: -There were several chunks of flooring missing in the main walkway. There was black tape over some of the missing tile pieces. -The rubber mat under one piece of exercise equipment had a large tear, potentially causing a	F 584		

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F 584	Continued From page 3 tripping hazard. -There was no light cover over one of the fluorescent light fixtures. It was unknown if those light bulbs were shatter-proof or not. -Interview with physical therapist assistant (PTA) Y at the time of the observation revealed the damage in the floor started over a year ago when the light fixture cover fell from the ceiling and hit the floor. -She indicated the maintenance department was aware of the flooring and light fixture issue. 3. Interview on 2/27/25 at 2:03 p.m. with maintenance director Z revealed: *He was aware of the bathroom ceiling. -There was a leak in the ceiling pipes, and he had to remove the plaster and cut a hole in the chicken wire. -He indicated that a contractor was supposed to have been fixing the ceiling the week of the survey or the next, but they rescheduled due to the survey. *He was aware of the damaged door frame. -He put spray foam in the damaged parts to temporarily minimize the draft that was blowing through. -He had contacted several contractors to fix the door frame but was having difficulties with the various contractors' schedules. -He started contacting contractors to fix the door frame in July 2024. *He was aware of the lack of a baseboard in the toilet/storage room. -Again, he stated that he was waiting on the contractor to schedule and address the issue. *He was not aware of the peeling and torn wallpaper in the whirlpool tub room. 4. Interview on 2/27/25 at 2:36 p.m. with interim	F 584		

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F 584	Continued From page 4 administrator AA revealed: *She was assisting with administrator duties as the new administrator had only been at that facility for about a week. *She was aware of the flooring issues in the therapy room. *A local flooring company recently provided a quote to fix the flooring in several areas of the building, including the therapy room, and she was waiting on the availability of funds for that project. *She was not aware of the issue with the deteriorating door frame but indicated that she knew a contractor that would be able to perform that task. 5. A "Homelike Environment" policy was requested on 2/27/25. The provider gave their July 2008 Preventative Maintenance policy. Review of that policy revealed: *"Policy Statement: ...The intent of this program is to establish a building where the environment is safe and comfortable, essential utilities are delivered without interruption and mechanical systems and equipment operate safely, accurately, and reliably." *"Procedure: - ...2. All areas of the Center and equipment therein, are inspected and maintained in accordance with the scheduled maintenance system (SMS). The Maintenance Department is responsible for the condition and function of the Center's physical plant, including utilities, grounds, and equipment. Each Center customizes the SMS to meet the specific needs of their building. Administrative authorized external service organization may be utilized as part of the SMS for complex systems or to meet code requirements in specific regions or locals."	F 584	1. All areas identified in the 2567 were repaired. 2. Environmental rounds were conducted by the Administrator and Director of Building Plant & Safety to identify other facility maintenance needs. Deficient findings were fixed. 3. The Administrator, Director of Nursing and Maintenance Director have reviewed the Homelike Environment Policy with the Director of Building Plant & Safety. All staff will be educated on what is a homelike environment, what they can do to make it a homelike environment and how to fill out and submit maintenance requests by 3/27/2025. 4. The Administrator or designee will conduct environmental rounds in 5 resident rooms weekly X4 weeks then monthly X2 months. The Administrator or designee will bring the audit findings to the monthly QAPI committee for further review and recommendations on continuing or discontinuing the audits.	3/27/2025

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F 657	Continued From page 5	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to revise and update a care plan to reflect the current needs for one of one (10) sampled resident with pressure ulcers to his heels and an abrasion to his coccyx. Findings include:	F 657		

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F 657	Continued From page 6 1. Observation and interview on 2/25/25 at 10:50 a.m. with resident 10 in his room revealed: *He was lying in bed and had a breakfast tray on his side table. *He stated he had wanted to stay in bed for breakfast. *He had a catheter and a feet elevation cushion (to keep heels off the bed) which was not positioned correctly, and his heels were touching the bed. Interview on 2/26/25 at 7:27 a.m. with registered nurse (RN) B revealed: *Resident 10 had a stage II pressure ulcer (wound with partial thickness skin tissue loss from prolonged pressure) on each heel. *She had already done the pressure ulcer wound care. Review of resident 10's electronic medical record (EMR) revealed he had: *A stage II pressure ulcer was found on his right heel on 8/26/2024. *A stage II pressure ulcer was found on his left heel on 1/3/2025. *A superficial abrasion to the coccyx (tail bone) was found on 2/25/25. Review of his last updated care plan on 5/30/2024 related to his skin impairment included: *Focus: "I have the potential for pressure ulcer development r/t [related to] Hx [history] of ulcers, immobility." *Goal: "I will have intact skin, free of redness, blisters or discoloration by/through review date." *Interventions: -"Elevate/float heels when in bed to offload pressure as I allow."	F 657		

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F 657	Continued From page 7 -"Follow facility policies/protocols for the prevention/treatment of skin breakdown." -"Frequent repositioning while resting." -"Inspect skin while providing cares, notify nurse of any new skin conditions." -"Instruct/assist/encourage me to shift weight in W/C [wheelchair] routinely." -"Pressure reducing air mattress to bed." -"Pressure reducing cushion to wheelchair." *There was no indication in his care plan that he had any pressure ulcers or abrasions on his skin. Interview on 2/27/25 at 12:27 p.m. with director of nursing (DON) A regarding resident 10's care plan revealed: *She was responsible for creating and updating resident care plans. *She agreed resident 10's care plan was not updated to reflect his individualized skin integrity needs and did not include he had pressure ulcers. Review of the provider's January 2025 Skin Integrity policy revealed: *"In the event that a resident is admitted with or develops a skin ulcer/pressure ulcer/wound, care is provided to treat, heal, and prevent, if possible, further development of skin ulcers/pressure ulcers/wounds." *"1. The nurse completes the Braden Scale/Skin Integrity Evaluation at admission, weekly for three weeks, and then annually. The Braden Scale is a guide to determine risk stratification for skin impairment." -"2. The nurse establishes a plan of care based on risk factors in an effort to limit their potential effects." -"3. The resident's skin is inspected daily with completion of ADL's [activities of daily living]	F 657	1. Resident #10's care plan was updated to reflect reassessment of skin issue. 2. The care plans of residents with pressure injuries were reviewed to ensure accuracy. Inaccuracies were corrected. 3. The Administrator, Director of Nursing and Interdisciplinary Team have reviewed the facility's Skin Integrity policy with an emphasis on the care planning section of the policy. The Director of Nursing or designee will educate nurses on this policy by 3/27/2025. Staff not in attendance will be educated prior to their next shift worked. 4. The Director of Nursing or designee will audit the care plans of any residents with new pressure injuries weekly X4 weeks, then monthly X2 months to ensure the proper care plan updates have been made. The Director of Nursing or designee will bring the audit findings to the monthly QAPI committee for further review and recommendations on continuing or discontinuing the audits.	3/27/2025

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F 657	Continued From page 8 (unless resident is independent in ADL completion). Changes in the resident's skin are reported to the Licensed Nurse (LN)." *"If skin impairment is noted after admission, the LN: -c. Implements new interventions as needed. Documents on the resident's care plan and ISP. -e. Notifies Director of Nursing Services (DNS) of skin Impairments that indicate a potential significant change in condition (State II or greater Pressure Ulcer, surgical wound dehiscence, hematoma, or bruise on an area of the body not usually vulnerable to trauma (e.g. head, breasts, inner thighs, groin)." The provider did not have a care plan policy.	F 657		
F 684 SS=G	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: Based on observation, interview, record review, and policy review, the provider failed to ensure quality of care was provided related to one of one sampled resident's (20) wound care improperly delegated by registered nurse (RN) R to certified nurse assistant (CNA) J, hospice coordination of care for two of two sampled residents (12 and 49), and pain management for one of one	F 684		

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F 684	Continued From page 9 sampled resident (49). Findings include: 1. Interview on 2/25/25 at 10:11 a.m. with resident 20 and his wife in their room revealed: *He had a sore on his bottom. *He was supposed to have his wound dressing changed every other day in the evenings. *Both resident 20 and his wife indicated that CNA J had performed the wound dressing change that previous evening. *They indicated that RN R was supposed to have completed the wound dressing change, not CNA J. *They described a specific type of ointment that was placed on the wound. They mentioned the word "collagen." Review of resident 20's electronic medical record (EMR) revealed: *His 1/7/25 annual Minimum Data Set assessment indicated a Brief Interview for Mental Status assessment score of 14, which indicated he was cognitively intact. *A 12/18/24 physician's order for "Posterior L &R [left and right] Thighs &L buttock Abrasions: Cleanse with wound cleanser, pat dry, apply Moistened Collagen [wound healing product] to wound beds, cover with Optifoam [wound dressing]. As needed for when falls off/after bath." -The treatment administration record (TAR) indicated that order had been last completed on 2/20/25 by RN E. *A 12/18/24 physician's order for "Posterior L &R Thighs &L buttock Abrasions: Cleanse with wound cleanser, pat dry, apply Moistened Collagen to wound beds, cover with Optifoam. Every day shift every 2 day(s) for Abrasions until	F 684		

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F 684	Continued From page 10	F 684		

healed."
-The TAR indicated that order had last been completed on 2/23/25 by RN B.

Interview on 2/26/25 at 4:08 p.m. with RN R revealed:
*Wound treatments were usually completed during the day shift.
*Resident 20 sometimes requested a new Optifoam dressing after he used the bathroom.
-If he requested a new dressing at night when she was "very busy," she would ask the CNA to apply the Optifoam dressing.
*The only treatment that she had completed for resident 20 on the evening shift was applying an ointment on his left hip for pain.

Interview on 2/26/25 at 4:26 p.m. and 4:35 p.m. with CNA J revealed:
*She confirmed that she had applied resident 20's ointment and dressing bandage when the nurse was busy.
*She could not remember what type of ointment she applied for resident 20, but she said it was yellow.
-She thought the yellow ointment might have been a barrier cream, but she was not sure.
-The nurse would give her the ointment in a medicine cup.
*She said that resident 20 had a bath the other day, and the nurse asked her to apply the yellow ointment and the bandage on his bottom.

Interview on 2/27/25 at 7:47 a.m. with DON A revealed:
*Resident 20 had Optifoam dressings on the back of his thighs directly underneath his buttocks, and on his coccyx region.
*The wounds on the back of his thighs were from

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F 684	Continued From page 11 an abrasion due to his briefs. He would slide back and forth in his recliner, which she thought caused friction abrasions. *He was independent with ambulation and toileting. *She confirmed it was not normal practice for a licensed nurse to delegate a treatment of applying a resident's ointment and dressing to a CNA. Review of the provider's March 2012 CNA job description revealed: *"Job Summary: Under general supervision performs a combination of following duties in caring for residents in the Center, consistent with the plan of care and established long-term care standards and Center policies and processes. The CNA is expected to perform duties in compliance with state and federal regulations." *"Reporting Relationships: 1. Reports to the Licensed Nurse directing and overseeing resident care on assigned unit." Review of the Administrative Rules of South Dakota (ARSD), Chapter 20:48:04.01 for Delegation of Nursing Tasks revealed: *"20:48:04.01:01. General criteria for delegation. A licensed registered nurse is responsible for the nature and quality of nursing care that a client receives under the nurse's direction. A licensed nurse may delegate selected nursing tasks to a nursing assistant. A nursing assistant may not substitute for the licensed nurse in the performance of nursing functions. A nursing assistant may not redelegate a delegated task. *"A licensed nurse shall assess a situation and determine whether delegating nursing tasks to a nursing assistant is appropriate. The delegation of nursing tasks to a nursing assistant must	F 684		

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 684	Continued From page 12 comply with the following criteria: -(1) The nursing task is one that a reasonable and prudent licensed nurse would find within the scope of sound nursing judgment to delegate; -(2) The nursing task is one that, in the opinion of the delegating nurse, can be properly and safely performed by a nursing assistant without jeopardizing the client's welfare; -(3) The nursing task does not require a nursing assistant to exercise nursing judgment; -(4) The licensed nurse evaluates the client's nursing care needs before delegating the nursing task; -(5) The licensed nurse verifies that the nursing assistant is competent to perform the nursing task; and -(6) The licensed nurse supervises the performance of the delegated nursing task in accordance with the requirements of ARSD Chapter 20:48:04.01:02." *"20:48:04.01:02. Supervision. The licensed nurse shall supervise all nursing tasks delegated to a nursing assistant in accordance with the following conditions: -(1) The licensed nurse determines the degree of supervision required after considering: --(a) The stability of the client's condition; --(b) The competency of the nursing assistant to whom the nursing task is delegated; --(c) The nature of the nursing task being delegated; and --(d) The proximity and availability of the licensed nurse to the nursing assistant when the nursing task is performed; -(2) The delegating nurse or another licensed nurse is readily available either in person or by electronic communication ..." 2. Observations and interviews made throughout the survey revealed residents 12 and 49 had not	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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

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F 684	Continued From page 13 been repositioned or transferred on a routine basis, which potentially contributed to the development of pressure ulcers on resident 12's coccyx first noted on 2/23/25, and on resident 49's coccyx first noted on 2/27/25. Interviews with RN E and RN R indicated they had not assessed resident 12's wound and had not obtained orders from a physician for treatment. Interviews with RN E and RN R indicated resident 12's hospice service was managing the wound, so they did not assess or treat the wound. Interviews with DON A throughout the survey revealed that she was not aware of resident 12's pressure ulcer, and she expected staff to conduct their own assessments and obtain treatment orders whether a resident was on hospice or not. Refer to F686, findings 14 through 27 regarding resident 12. 3. Observations and interviews throughout the survey revealed that resident 49 was experiencing consistent pain with repositioning. There were several instances where he was heard moaning and shouting out in pain. He was seen grimacing in pain. Record review revealed that he had orders for "as needed" pain management, but that had not been administered due to pain assessment documentation showing as a "0 out of 10" on three separate occasions on 2/25/25. Interviews with hospice staff revealed that they had concerns about previous residents and their pain, which was to be managed by the provider. By not recognizing that the resident was experiencing increased pain and not	F 684	1. Resident #20's wound was assessed and their treatment was reviewed on 3/20/2025. Residents #12 and #49 no longer reside in the facility. 2. Hospice and Center Coordination Forms were completed and reviewed with the hospice provider on 3/20/2025. Residents with pain were evaluated to validate appropriate interventions. 3. The Director of Nursing or designee will educate nursing staff on the following: -Scope of practice -Pain management -Hospice Coordination of Care -Skin Integrity -Wound care and prevention The above education will be completed by 3/27/25. All nursing staff not in attendance will be educated prior to their next shift worked. 4. The Director of Nursing or designee will audit 3 wound dressing changes weekly on differing shifts to ensure the ordered dressing is in place and that appropriately licensed staff performed the dressing change. The Social Services Director or designee will audit all new hospice admissions to ensure the Hospice Coordination of Care Form was complete. These audits will be conducted weekly X4 weeks, then monthly X2 months. The Director of Nursing and Social Services Director will bring the audit findings to the monthly QAPI committee for further review and recommendations on continuing or discontinuing the audits.	3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 684	Continued From page 14 administering the prescribed pain medication, resident 49 experienced pain with personal cares and repositioning. Refer to F697.	F 684		
F 686 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 from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and job description review, the provider failed to develop and implement pressure relieving measures to ensure facility acquired pressure ulcers had not developed for three of five sampled residents (10, 12, and 49) who were identified at high risk for skin breakdown and dependent upon the staff assistance with their activities of daily living (ADL). Findings include: 1. Observation on 2/25/25 at 10:08 a.m. of resident 10 revealed: *He was in his room and lying on the bed with a	F 686		

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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

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F 686	Continued From page 15 nursing home gown on. *He was laying mostly on his back with a pillow placed underneath of his right arm. -His body was positioned and was facing towards the wall with the upper portion of his body towards the left of the bed. -From his waist down his body was laying on the right side of the bed. -His buttocks and thighs laid directly on the mattress. *There was a heel lift device underneath the lower part of his legs to help decrease pressure from the mattress on his heels. -He had been positioned low in the bed and his left foot was flat up against the footboard. *His left ankle was laying directly on the edge of the mattress and his right heel was laying directly on the mattress. -There was no pressure relief for his left ankle from the edge of the mattress or his foot from the footboard. *He had been awake and watching television. 2. Random observations on 2/25/25 from 11:10 a.m. through 2:20 p.m. and interview with resident 10 revealed: *He had been lying in the same position as observed above. *He was either sleeping or watching television during those observations. *He had a towel placed underneath his chin that had a brown stain on it from some type of liquid. *He was not observed getting out of bed for breakfast or lunch. *When asked if he was getting out of bed today, he asked what day it was and then stated, "Yes." 3. Interview on 2/26/25 at 7:27 a.m. with registered nurse (RN) B revealed:	F 686		

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

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F 686	Continued From page 16 *Resident 10 had a stage two pressure ulcer (wound with partial thickness skin tissue loss from prolonged pressure) on each heel. *She had already completed his pressure ulcer wound care that day. 4. Observation on 2/26/25 at 8:00 a.m. of resident 10 revealed: *He had been lying in bed with his body propped onto his left side by a pillow. *His feet, ankles, and heels were in the same position as observed the day before (2/25/25). 5. Interview on 2/26/25 at 8:05 a.m. with certified nursing assistants (CNAs) V and W regarding resident 10 revealed: *He did not like to get out of bed and often refused. *He could reposition himself but they would have to verbally cue him to turn over. *The surveyor had requested to watch them provide personal cares for him. *CNA V stated: "Not sure when today but will at some point." 6. Random observations on 2/26/25 from 8:45 a.m. through 12:10 p.m. of resident 10 revealed he had been in the same position as observed above for the entire morning. At 12:10 p.m. CNA W came and got the surveyor to observe them providing his personal care. 7. Observation on 2/26/25 at 2:49 p.m. of resident 10 revealed he was in his wheelchair at bingo. 8. Observation and interview on 2/27/25 at 7:18 a.m. with RN B while she provided wound care treatment to resident 10 revealed: *He had given the surveyor permission to	F 686		

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 686	Continued From page 17 observe his wound care. *He had a stage two pressure ulcer on his right and left heels. *He had an abrasion on his coccyx (tail bone). *RN B stated the wounds were facility acquired. *Staff were to complete wound assessments once a week. *Skin assessments were to be completed weekly on the residents' bath days, and they label a "yes" or "no" if there was a new skin condition or not. *If there was a new skin condition, then staff would complete a weekly skin evaluation form. 9. Interview on 2/27/25 at 12:27 p.m. with director of nursing (DON) A revealed: *She thought all facility acquired pressure ulcers were preventable including resident 10's. *She did not think the staff were providing the residents' pressure ulcer prevention measures or completing skin assessments on residents who had risks of acquiring pressure ulcers. *She wanted to start plan of care (POC) charting task that would include including repositioning residents every two hours and toileting. *She planned to start staff competencies including what to look for during skin assessments and how to document them. 10. Review of resident 10's electronic medical record (EMR) revealed: *An admission date of 4/5/24. *He had a Brief Interview for Mental Status (BIMS) assessment score of 15 which indicated he was cognitively intact. *His diagnoses included venous insufficiency, hypertension, chronic kidney disease, and diabetes. *He was dependent on staff for bathing, bed mobility of moving right and left, transferring out	F 686		

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 686	Continued From page 18 of bed, toileting, and implementing any preventative interventions to ensure skin breakdown would not have occurred. *A stage two pressure ulcer was acquired on his right heel on 8/26/2024. *A stage two pressure ulcer was acquired on his left heel on 1/3/2025. *A superficial abrasion to his coccyx was acquired on 2/25/25. 11. Review of resident 10's care plan last updated on 5/30/2024 related to his skin integrity included: *Focus: "I have the potential for pressure ulcer development r/t [related to] Hx [history] of ulcers, immobility." *Goal: "I will have intact skin, free of redness, blisters or discoloration by/through review date." *Interventions: -"Elevate/float heels when in bed to offload pressure as I allow." -"Follow facility policies/protocols for the prevention/treatment of skin breakdown." -"Frequent repositioning while resting." -"Inspect skin while providing cares, notify nurse of any new skin conditions." -"Instruct/assist/encourage me to shift weight in W/C [wheelchair] routinely." -"Pressure reducing air mattress to bed." -"Pressure reducing cushion to wheelchair." *There was no indication on his care plan that he had any pressure ulcers or abrasions on his skin. 12. Review of resident 10's Braden Scale for Predicting Pressure Sore Risk assessments revealed: *On 2/23/24 and 5/17/24 his score was a fourteen which indicated he had moderate risk for the development of a pressure ulcer. *On 8/13/24 and 9/16/24 his score was a fifteen	F 686		

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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

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F 686	Continued From page 19 which indicated he had mild risk for the development of a pressure ulcer. *On 12/13/24 his score was a sixteen which indicated he had a mild risk for the development of a pressure ulcer. 13. Review of a 2/24/25 weekly skin evaluation for resident 10 signed by RN B revealed: *The left heel had a stage two pressure ulcer acquired on 1/3/25. It: -Had minimal drainage and measured 1 centimeter (cm) in length, 1 cm in width, and 0 cm in depth. -Required pressure-reducing interventions including a mattress and boots. -Had a dressing order to cleanse, pat dry, apply silicone cream, cover with Optifoam (a type of wound dressing), and change daily. *The right heel had a stage two pressure ulcer acquired on 8/26/24. It: -Had no drainage and measured 1 cm in length, 2 cm in width, and 0 cm in depth. -Worsened from a stage one on 2/17/25 to a stage two on 2/24/25. -Had the same dressing order as the left heel. 14. Random observations on 2/25/25 from 9:45 a.m. through 2:20 p.m. of resident 12 revealed: *She had been in her room sitting in a recliner. *Her feet were elevated by the footrest, and she appeared to have been sleeping. *Staff were not observed assisting her to offload or reposition/transfer to another location such as her bed. 15. Observation on 2/25/25 at 3:18 p.m. of resident 12 in her room revealed: *She had been moved to her wheelchair. *She was sitting on an inflatable cushion.	F 686		

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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F 686	Continued From page 20 16. Random observations on 2/26/25 from 7:45 a.m. through 11:20 a.m. of resident 12 revealed: *There was a heel lift device (a device that helped decrease the pressure from the mattress on a person's heels) that was not in use. It was sitting on the other bed in her room. *She had been lying in her bed sleeping. *She had an air mattress overlay on her bed to help with relieving pressure to any areas that would have been at risk for skin breakdown. *She had been laying on her back, both of her heels were positioned directly on the air mattress, and the bottoms of her feet were positioned against the footboard of the bed. *She remained in that position for over three hours. *At 8:00 a.m. the surveyor asked CNA D to observe them assisting the resident. He stated that he would come and get that surveyor when that happened. 17. Review of resident 12's EMR revealed: *A nursing progress note from 2/23/25 at 11:30 a.m. that read, "Called [hospice provider] to update on Res [resident] refusing pain medication and new skin issues. Hospice nurse will come to assess resident today." *A scanned "Coordination Notes Report" hospice note that was signed as "noted" by DON A on 2/25/25. -It included six pages of notes and assessment details. DON A signed the first page. -On 2/23/25, RN E called the hospice triage phone number to discuss concerns with resident 12 refusing pills and "[RN E] states that she believes [resident 12] may be developing a Kennedy ulcer [an ulcer that can develop rapidly as a person is in the dying process] on her coccyx, as she has discoloration that is purple in	F 686		

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F 686	Continued From page 21 color and described as a stage 1." -"[Resident 12] also has an injury to the back of her left thigh caused by catheter tubing pressing against her skin." -"No current wound care orders for either area are present at [the] facility at this time." -"[RN E] does not think skin issues have been assessed by hospice yet." -Later in the day on 2/23/25, a hospice RN was present at the facility and noted that RN E was present to assist with assessments. -"Wound measures 2.5cm [centimeters] [by] 7.5cm dark purple area with a 1.5cm [by] 1.5cm open area in the center. Wound picture taken and care plan updated. Orders placed along with calendar updated." *A weekly skin audit had been completed on 2/20/25 after her bath with no new skin impairment identified. *There were no physician's orders or wound assessments found regarding the skin impairments on her coccyx and thigh. 18. On 2/26/25, a list of all residents with current skin and wound concerns was requested and interview on 2/26/25 at 8:27 a.m. with DON A regarding that list revealed: *Resident 12 was not on that list. *She was not aware that resident 12 had any skin issues relating to her coccyx or thigh. *She was aware that the hospice provider wanted to look at her skin, but she was not aware of any current skin issues. *Additional documentation relating to wound assessments and treatment orders was requested relating to resident 12's wounds. Continued interview on 2/26/25 at 8:35 a.m. and 9:27 a.m. with DON A revealed:	F 686		

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 686	Continued From page 22 *She could not find any orders from hospice regarding wound care. -She had to call the hospice provider to obtain their wound assessments and treatment orders. *She did not know if resident 12's primary care physician was notified of the wounds. *She confirmed she missed the wound assessment note from hospice on 2/23/25. *She confirmed she had signed her initials on that hospice note on 2/25/25. *They had recently changed their process on how they were to complete residents' weekly skin assessments. -Previously, the nurse would complete a weekly skin audit evaluation on each resident. -Now, they have a "yes or no" question that was triggered weekly. The nurse would check "yes" if there was a skin issue and that would trigger a full skin assessment. If "no" was checked, that meant no new skin impairments. *They implemented the following measures to prevent pressure ulcers for resident 12: -An air mattress. -The cushion for her wheelchair. -"Calmo" brand skin barrier cream. 19. Observation and interview on 2/26/25 at 10:20 a.m. with RN X regarding resident 12 revealed: *She was massaging resident 12's hands and washing her face. *She was the hospice care case manager and had come in that day to see the resident. *She was not there to complete personal care for the resident but to offer comfort and support in other measures. *She would have expected the residents on hospice care to have been repositioned at a minimum of every two hours. *The resident had recently acquired a Kennedy	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 23	F 686		

ulcer to her coccyx area.
-That ulcer had the potential to worsen when proper repositioning had not occurred.
*They would have completed a wound assessment for their own purposes and records.
-That skin assessment would not have been provided for the facility's records.
-The facility was responsible for completing their own skin assessments.
-The residents were still the primary responsibility of the facility.
-She explained that hospice services were an additional support for the resident.

20. On 2/26/25 at 11:20 a.m., CNA U came and got the surveyor to observe them assisting the resident. That had been the first time in the morning that the staff had assisted her with repositioning and personal care.

21. Interview on 2/26/25 at 12:58 p.m. with RN E about resident 12's wound revealed:
*She noticed the bruise on resident 12's coccyx on Sunday 2/23/25. The area was purple.
*She did not assess it at that time because "I didn't want to be pressing on it. I didn't know if it was a deep tissue injury."
*She called the hospice provider because "Hospice takes care of the wound care orders and the assessments."
-The hospice provider indicated that they would send someone that day to assess the wound.
*She did not notify the resident's primary care physician, saying, "I didn't even think to do that."
-She also did not notify the DON because she did not want to disturb her on a Sunday.
*She passed the information along to RN R who was the oncoming nurse for the next shift.
*For pressure ulcer preventative measures, she

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 686	Continued From page 24 expected staff to reposition resident 12 on a regular basis, such as moving from the bed to a chair, shifting to different positions in the chair, and moving her to the wheelchair. *Resident 12 had an air mattress on her bed and a cushion in her chair for pressure redistribution. 22. Observation on 2/26/25 at 1:08 p.m. of resident 12 revealed that she was dressed for the day and had been moved to her recliner. 23. Observation on 2/26/25 at 4:07 p.m. of resident 12 revealed that she was still sitting in her recliner. The recliner was in a slight reclined position. 24. Interview on 2/26/25 at 4:53 p.m. with RN R revealed: *She confirmed she was present at the facility on 2/23/25 when the hospice nurse came to assess resident 12's wounds. *She did not perform a wound assessment because hospice did the assessment. -The hospice nurse measured the wound. -"She asked me to apply Optifoam and that's it." -At the time of the assessment, resident 12's coccyx was red and there was a "little bit of scraping" and bleeding. *She did not notify the resident's primary care physician because "they have their own hospice physician and hospice staff notify the physician." *She did not notify the DON. *She indicated that if the hospice nurse had a new order, she would have entered it into the EMR system, and the DON would have been notified that way. -There were no new orders that she entered from hospice regarding that wound. *Wound treatments were usually completed	F 686		

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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

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F 686	Continued From page 25 during the day shift. 25. Interview on 2/27/25 at 8:05 a.m. with DON A revealed: *She expected staff to complete assessments on wounds when they were noticed right away, complete the skin evaluation, and notify the family and physician. *They used telehealth services to obtain treatment orders. *That process should not change due to a resident receiving hospice services. *She explained that hospice was an additional service, and staff should not be passing along the responsibility of caring or a resident onto the hospice service. 26. Review of resident 12's current care plan revealed: *She was completely dependent on staff and required substantial to maximum assistance for ambulation, transferring, and repositioning. *One intervention read, "Skin at risk: Barrier cream, Lotion to dry skin, Pressure reducing mattress, Specialty mattress: Air Mattress, Turn/reposition routinely, Wheelchair cushion." Initiated on 10/4/23. Revised on 1/31/24. *There were several interventions that mentioned she experienced frequent loose stools and was incontinent of her bowels. Her care plan indicated for "Staff to cleanse and keep skin dry. Apply barrier cream BID [twice per day] and with each incontinent episode." *She preferred to lay on her back and would only reposition to her side for short periods of time. *Pressure-reducing measures included the specialty air mattress and a pressure reducing cushion in her wheelchair. *She had a history of a venous ulcer to the	F 686		

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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F 686	Continued From page 26	F 686		

bottom of her right foot.
*Another intervention that read, "Utilize pillows/foam wedges for placement between bony prominences." Initiated on 3/16/25. Revised on 2/13/24.

27. Review of resident 12's EMR revealed:
*Her diagnoses included endometrial cancer, multiple sclerosis, type 2 diabetes, peripheral vascular disease, and congestive heart failure, among others.
*A significant change Minimum Data Set assessment was completed on 1/6/25 that included:
-Her BIMS assessment score was 10, which indicated she was moderately cognitively impaired.
-She was dependent on staff to transfer from surface to surface.
-She required substantial to maximum assistance for repositioning.
-She had a catheter due to a neurogenic bladder, and she was "always" incontinent of bowel.
-She was at risk for developing pressure ulcers.
-She did not have any pressure ulcers at the time of the assessment.
28. Observations on 2/25/25 from 9:45 a.m. through 3:00 p.m. of resident 49 revealed:
*At 9:45 a.m., the resident was laying on his back with a pillow under his back on the right side, but mostly flat.
*At 1:10 p.m., the resident was laying in the same position, mostly flat, with a pillow under his back on his left side.
*At 2:15 p.m., the hospice nurse was at his bedside, the pillow was moved to right side, and the resident laying mostly flat.
*At 3:00 p.m., his position was unchanged.

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 27 29. Interview on 2/26/25 at 7:50 a.m. with RN E revealed resident 49 was to be repositioned every two hours to help prevent pressure ulcers. 30. Observation and interview on 2/26/25 at 8:10 a.m. with certified medication aide (CMA) D revealed: *He was repositioning resident 49 every two hours. *He reported the resident's condition had significantly declined over the past few days. *During observation of repositioning, resident 49 was unable to follow commands and moaned in pain when moved. 31. Observations on 2/26/25 of resident 49 revealed: *At 9:00 a.m. he had been in bed and was laying on his back. -The extra pillow had been placed above his head. -Both of his feet and heels had been laying directly on the mattress with no pressure relieving device in place. -He had been positioned down low on the mattress to where his feet rested directly up against the footboard. 32. Interview on 2/26/25 at 12:30 p.m. with CNA U revealed: *Residents should have been repositioned every two hours. *He agreed: -Residents 12 and 49 were dependent upon the staff to reposition them. -Those residents were vulnerable and were at risk for skin breakdown and should have been repositioned every two hours. *His partner had left early that day, and he was	F 686		

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 28 left by himself to reposition them. -He confirmed those residents had gone longer than two hours without being repositioned. *He agreed: -Repositioning residents with their feet directly against the footboard created the potential for skin breakdown to have occurred. -The residents' heels should not have been left directly on the mattress. A heal lift should have been used to relieve the pressure. 33. Observation on 2/26/25 at 4:30 p.m. of CNA K revealed: *She was changing resident 49's brief because he had been incontinent. *There was a bandage on resident's buttock. *CNA was not sure what the bandage was covering but would let the charge nurse know it was starting to peel away from his skin. 34. Interview on 2/26/25 at 5:20 p.m. with hospice nurse RN G revealed: *She reported doing resident 49's skin assessments. *She reported there was some redness to the resident's coccyx, but did not believe there were any pressure ulcers. 35. Observation and interview on 2/27/25 at 10:47 a.m. with RN B revealed: *She was performing skin cares on resident 49's coccyx and buttocks. *After removing cream from resident's coccyx, two open area were revealed, each measuring approximately one centimeter (cm) around. *She reported these to be stage two pressure ulcers. *She reported this was the first time she had seen these ulcers.	F 686		

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F 686	Continued From page 29	F 686		

*She reported when performing resident cares on 2/24/25, the ulcers were not present.
*She did not feel the ulcers could have been prevented because resident was repositioned appropriately.

36. Interview on 2/27/25 at 12:33 p.m. with DON A revealed:
*She found out about resident 49's pressure ulcers earlier in the morning.
*Regarding resident 49's pressure ulcers, she felt they were "absolutely preventable."
*Regarding facility acquired pressure ulcers, she felt they are all preventable.
*She did not think CNAs received appropriate training.
*She felt sometimes staff did not listen to her guidance in regard to the education she provided them.
*She wanted to implement POC [point of care] documenting. (The care is documented at the time it occurs, not when it is scheduled). This would increase accountability of completing resident tasks.
*It was her expectation for staff to follow her instructions.
*She planned to implement a competencies program with a skills checklist.
-She was hopeful with the hiring of a new assistant DON education of staff and competencies could soon become a priority.

37. Review of resident 49's EMR revealed:
*He was admitted to hospice care on 2/18/25.
*His BIMS assessment score was three, which indicated he was severely cognitively impaired.
*He had medical diagnoses including Alzheimer's/dementia with behaviors, fall with major injury, right humerus fracture, congestive

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 686	Continued From page 30 heart failure, and depression. *He was dependent upon the staff to: -Assist him with all of his mobility needs (repositioning in bed) and ADL. -Implement any preventative interventions to ensure skin breakdown would not have occurred. -Anticipate his needs as he was unable to make them known. *His Braden Scale score on 2/20/25 was sixteen. -That score had indicated he was at mild risk for skin breakdown. *On 2/27/25 his Braden Scale score was reassessed and was an eight. -Within seven days his skin breakdown risk had increased to a very high risk. *The first documentation of his pressure ulcers was in nursing progress note on 2/26/25 at 11:59 p.m. by RN R, after his skin bandage was witnessed earlier in the day. -"Resident in bed PM cares. Reposition to sides. No intake. Took his comfort meds. Hospice nurse here after supper. Both writer & hospice nurse [name], we did measure open sores. Coccyx one cm [centimeter] x 3/4 cm. Right cheek [buttock] 1 cm x 3/4 cm." 38. Review of resident 49's care plan revealed: *A focus of " I have the potential for impairment to skin integrity r/t [related to] edema, fragile skin." *Goals of "The resident will maintain or develop clean and intact skin by the review date. The resident will be free from injury through the review date." *Interventions/tasks of "Avoid scratching and keep hands, and body parts from excessive moisture. Follow facility protocols for treatment of injury. Keep skin clean and dry. Use lotion on dry skin. The resident needs pressure reducing cushion to protect the skin while up in chair. The	F 686		

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 686	Continued From page 31 resident needs pressure reducing mattress to protect the skin while IN BED. Use draw sheet or lifting device to move resident." 39. Review of the provider's January 2025 Skin Integrity policy revealed: *"In the event that a resident is admitted with or develops a skin ulcer/pressure ulcer/wound, care is provided to treat, heal, and prevent, if possible, further development of skin ulcers/pressure ulcers/wounds." *"1. The nurse completes the Braden Scale/Skin Integrity Evaluation at admission, weekly for three weeks, and then annually. The Braden Scale is s guide to determine risk stratification for skin impairment." -"a. Residents are at a level of risk per the Braden scale and the completion merely guides the practitioner to determine if future intervention is required." -"2. The nurse establishes a plan of care based on risk factors in an effort to limit their potential effects." -"3. The resident's skin is inspected daily with completion of ADL's [activities of daily living] (unless resident is independent in ADL completion). Changes in the resident's skin are reported to the Licensed Nurse (LN)." -"Ongoing evaluation continues weekly with the LN completing a full body skin audit. Completion of the skin audit is documented on the Treatment Administration Record (TAR) with their initials, and either a 'No' or 'Yes.'" *"If skin impairment is noted after admission, the LN: -a. Initiates alert charting. -b. Completes (and documents) notifications to the physician and Resident or Resident Representative.	F 686	1. Resident #10 was assessed for any skin integrity issues. Appropriate skin interventions were put in place. Resident #12 and #49 no longer reside in the facility. 2. A facility-wide skin integrity audit was conducted. Residents with identified skin integrity issues have had appropriate interventions implemented. 3. The facility assigned a dedicated wound nurse. This wound nurse trained/rounded with a wound certified nurse practitioner who will continue to support the dedicated wound nurse while she obtains her wound care certification. All nursing staff will be educated on the skin integrity policy, wound care education, repositioning and scope of practice by 3/27/2025. 4. The Director of Nursing or designee will audit all new and worsening pressure injuries weekly X4 weeks and monthly X2 months to ensure all new or worsening pressure injuries have treatment orders and appropriate interventions in place. The Director of Nursing or designee will bring the audit findings to the monthly QAPI committee for further review and recommendations on continuing or discontinuing the audits.	3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 686	Continued From page 32 -c. Implements new interventions as needed. Documents on the resident's care plan and ISP. -d. Notifies Food and Nutrition Services Manager (FANS) and/or Registered Dietician of new pressure injury or worsening wound condition for nutritional needs evaluation. -e. Notifies Director of Nursing Services (DNS) of skin Impairments that indicate a potential significant change in condition (State II or greater Pressure Ulcer, surgical wound dehiscence, hematoma, or bruise on an area of the body not usually vulnerable to trauma (e.g. head, breasts, inner thighs, groin). -f. The DNS and/or designee complete a comprehensive review of the resident's medical record to evaluate if the pressure injury was avoidable or unavoidable. This evaluation is documented in the Nurse's Notes." *"If a wound condition fails to improve after 2 weeks of treatment or the condition of the wound deteriorates, the Physician and Resident's Representative are notified." 40. Review of the provider's March 2012 CNA job description revealed: *"Essential Functions: ...5. Turns and repositions bedfast residents, alone or with assistance, and utilizing proper body mechanics, to prevent pressure ulcers."	F 686		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 697	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, interview record review and policy review provider failed to recognize and adequately manage pain for one of two hospice sampled resident (49). Findings include: 1. Observation on 2/25/25 at 2:11 p.m. revealed: *Resident 49 was being repositioned by certified nursing assistant (CNA) F and hospice registered nurse (RN) G. *Resident 49 could be heard in the hall moaning. *Resident grimaced and moaned in pain with any repositioning. 2. Observation and interview on 2/26/25 at 8:31 a.m. with CNA D revealed: *CNA was repositioning and checking resident 49 for incontinence every two hours. *Resident 49 grimaced and moaned in pain with even small movement. *Resident 49 would shout "help", "help" with repositioning. *CNA made effort to be very gentle with the resident, but the resident was still in pain. *He reported resident 49 has had increased pain with repositioning for the past several days. *CNA reported his increased pain to RN E. 3. Interview on 2/26/25 at 8:40 a.m. with RN E revealed: *She tried to assess resident 49's pain as often as possible. *She also relied on the CNAs to let her know if he was having increased pain. *She was aware he was having increased pain with repositioning. *She did not feel his pain was adequately controlled with pills; she would prefer liquid	F 697		

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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

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F 697	Continued From page 34 morphine for pain control for a hospice resident. 4. Interview on 2/26/25 at 1:30 p.m. with director of nursing (DON) A and RN C revealed: *It was DON A's expectation resident 49 would be repositioned every two hours. *RNC C stated pain should be assessed every shift. *There were changes to resident 49's medication that day and DON A would like to see if the new medication was effective in relieving the resident's pain. 5. Phone interview on 2/26/25 at 2:15 p.m. with hospice RN G revealed: *She had no concerns with the quality of care resident 49 was receiving from the provider's staff. *She recognized the resident's increased pain during her previous visit and requested a change of pain medication to scheduled morphine. *She reported observing past hospice residents not having their pain controlled. She reported she thought resident pain was perceived as behavior issues. 6. Observation and interview on 2/26/25 at 4:30 p.m. with CNA K revealed: *CNA K was repositioning and checking the resident's brief for incontinence. *She reported the resident appeared to be more comfortable than usual. *She reported the resident seemed to have a lot of pain with movement and repositioning. 7. Review of resident 49's electronic medical record (EMR) revealed: *He was admitted to hospice care on 2/18/25. *His brief interview for mental status (BIMS)	F 697		

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 697	Continued From page 35 score was was 3, which indicated he was severely cognitively impaired. *He had medical diagnoses including right humerus fracture, congestive heart failure, and depression. *Nursing progress note on 2/25/25 at 1:11 a.m. documented by licensed practical nurse (LPN) S noted "Repositioned q [every] 2 hrs [hours]. He is lethargic, but yells every time he is touched. Refuses to eat, drink, and take medication." 8. Review of resident 49's 12/30/24 care plan revealed: -A Focus of "I am on pain medication therapy r/t [related to] injury to R [right] Humerus fx [fracture]. -Goals of "The resident will be free of any discomfort or adverse side effects from pain medication through the review date." -Interventions/tasks of "Administer ANALGESIC medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT [every shift]." -A Focus of "I have an alteration in musculoskeletal status r/t fracture of the R Humerus." -Goals of "The resident will remain free from pain or at a level of discomfort acceptable to the resident through the review date." -Interventions/tasks of "Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance." "Give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness." -A Focus of "I have identified PAIN that interferes with sleep, rehabilitation activities, day to day activities Depression, Fracture of R Humerus." -Goals of "The resident will not have an	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 697	Continued From page 36 interruption in normal day to day activities due to pain through the review date." "The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. " "The resident will display a decrease in behaviors of inadequate pain control such as irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, groaning, crying through the review date." -Interventions/tasks of "Administer analgesia as per orders. Give ½ hour before treatments or care." "Anticipate the resident's need for pain relief and respond immediately to any complaint of pain." 9. Review of resident 49's treatment administration record (TAR) revealed: *His pain was to be monitored each shift, at 7:00 a.m, 3:00 p.m., and 11:00 p.m. *On 2/25/25 at 7 a.m., RN CC documented the resident's pain was 0 out of 10 during repositioning, indicating the resident had no pain. *On 2/25/25 at 3 p.m., RN R documented resident's pain 0 out of 10. *On 2/25/25 at 11 p.m., LPN DD documented resident's pain 0 out 10 *Resident 49 had a physician's order to receive 2.5 milligrams (mg) of Oxycodone (narcotic pain medication) every hour as needed for pain. *On 2/25/25, resident 49 did not receive Oxycodone for pain. 10. Review of the provider's 1/2025 pain management policy revealed: *"Policy Statement: It is the policy of the center that residents receive care to attain and maintain the highest quality of care and life." *"Residents are evaluated for pain upon admission, routinely, and prn [as needed] with the	F 697	1. Resident #49 no longer resides in the facility. 2. An audit was completed to review resident pain monitors and associated care plans to validate interventions in place were appropriate and effective. Residents were interviewed for adequate pain management, and those unable to be interviewed the PAINAD scale was utilized during movement, in addition to staff interview, to determine if pain symptoms were noted. Issues identified were addressed. 3. The Director of Nursing has reviewed the facility's Pain Policy. All nursing staff will be educated on the policy by 3/27/25. Those not in attendance will be educated prior to their next shift worked. 4. The Director of Nursing or designee will audit the pain monitoring for each resident and ensure pain their pain interventions are reflected on their care plan. These audits will be conducted 3 times weekly for 3 months.The Director of Nursing or designee will bring the audit findings to the monthly QAPI Meeting.	3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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

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F 697	Continued From page 37 RAI [resident assessment instrument] process." *"Procedure: 2. The resident is evaluated every shift for signs and symptoms of pain, receiving pain management according to the Preliminary Plan of Care and/or physician order. This data is collected on the medication administration record (MAR), in the interdisciplinary progress notes and through the Daily Clinical meeting process. *"An appropriate pain scale is selected for use based upon resident ability and needs. Examples may include but are not limited to: Numeric 1-10, Verbal Descriptor Scale, Wong-Baker Faces, and the Pain AD (Pain Assessment in Advanced Dementia)." *"11. If the resident is a hospice client or receiving palliative/comfort care the nurse and the hospice manager collaborate to develop and evaluate the pain management plan of care.	F 697		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		

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F 812	Continued From page 38 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to maintain standard food safety practices including: *Unsanitary kitchen equipment and food storage and preparation areas including the dishwasher, the stovetop range, the convection oven, the walk-in cooler and freezer, the emergency food supply area, and the kitchenettes. *Improper food storage throughout the facility including storing foods past its quality date, storing foods that were visibly rotting, unsealed foods open to air in the cooler, storing raw meats above milk cartons, storing foods on the floor in the cooler, storing measuring scoops inside food thickener, and not labeling or dating bulk food ingredient items. *Improper hand hygiene and glove use during one of one meal service observations by two of two staff members (dietary manager L and an unidentified staff person). *Incomplete temperature monitoring for two of at least three communal resident food and beverage refrigerators. Findings include: 1. Observation during the initial kitchen tour on 2/25/25 from 8:28 a.m. through 9:09 a.m. of the dish room revealed: *There was a fan blowing into the dish room. The back of the fan was covered with a thick layer of dust. *A large section of the tile flooring, about three feet by nine feet, was missing, and the subfloor beneath it was exposed.	F 812		

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 812	Continued From page 39 *There was a large puddle of water under the dishwasher. *The metal paneling under the dishwasher was coming loose from the floor. Water splashed out from underneath the metal paneling when it was stepped on. *There was a limescale buildup throughout the dishwasher: -On both the top and bottom wash arms. -On top of the dishwasher. -Along the edges of the dishwasher doors. *There was a thick layer of food scum buildup along the top inside edge of the dishwasher. *The ventilation hood above the dishwasher had a buildup of rust and wet dust, suggesting poor ventilation from that hood. *The paint on the ceiling was peeling off. *Interview at that time with dietary manager L revealed: -One of the cooks was responsible for deliming the dishwasher every Wednesday. There was no documentation to show when that was last completed. -He was aware that the ventilation hood might not have been functioning properly. 2. Observation during the initial kitchen tour on 2/25/25 from 8:28 a.m. through 9:09 a.m. of the main kitchen area revealed: *The drip tray under the stovetop range was filled with food crumbs, burnt-on stains, and burned rotini noodles. *The backsplash of the stovetop range and flattop grill was stained black with burnt-on grease stains. *The tunnel that went from the flattop grill to the grease trap drawer was caked with black grease. *The trash can to the left of the stovetop was uncovered. There was a cover available and	F 812		

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 40 hanging off the trash can. *There were two ovens stacked on top of each other. The inside of the bottom oven was covered in burnt-on food and grease. *There were three bins of bulk food ingredients. One bin contained rice, another bin contained what looked like sugar, and the third bin contained what looked like flour. None of the bins were labeled or dated when they had been filled. *There was another uncovered trash can to the left of those bulk food ingredient bins. The cover was lying on the floor under the trash can. *There were several large containers of dried spices. Some of the containers had been there for several years, including a bottle of dried oregano with a delivery date of 9/4/18. 3. Observation during the initial kitchen tour on 2/25/25 from 8:28 a.m. through 9:09 a.m. in the walk-in cooler and freezer revealed: *There was an abundance of an unidentified black and white fuzzy growth on the walls, door frame, floor, and shelving units that appeared to have been mold. *The floor in the cooler was vinyl flooring that was damaged and curling up. *There was a buildup of dirt, food scraps, and packaging on the floor. *There was a crate of four gallons of milk sitting directly on the floor. *A box of raw bacon was stored directly above several gallons of chocolate milk. *Several food items were past the manufacturer's best by date: -Three jars of Grey Poupon mustard, one opened, with the best by date of 1/12/25. -One case of at least 10 jars of parmesan cheese with a best if used by date of 12/20/24. That case was delivered on 6/10/24.	F 812		

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

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F 812	Continued From page 41 *Several food items had started to rot: -Two bags of celery were visibly turning brown and mushy. -One bag of lettuce was starting to wilt and turn brown. There was brown liquid in the bag. *The wooden floor inside of the freezer had turned black. There was an abundance of dirt, food, dust, and food wrappers. *Refer to F908, finding 1, for details on how the cooler and freezer were malfunctioning. 4. Observation during the initial kitchen tour on 2/25/25 from 8:28 a.m. through 9:09 a.m. revealed in the storage room where the emergency food supply was stored: *There was a layer of dust, dirt, and cobwebs on the emergency food supply. *Most of the food in the emergency supply was delivered on 11/15/22 and was past the manufacturer's best by date. 5. Observation on 2/25/25 from 12:54 p.m. to 1:38 p.m. during the lunchtime meal service revealed: *An unidentified staff person wore the same pair of gloves throughout the meal service and did not wash his hands. With those gloved hands he: -Pushed a cart of drinks and served them to residents. -Pushed a resident in their wheelchair to her designated table. -Grabbed coffee mugs and plastic cups, poured drinks into them, and served them to residents. -Grabbed a tray of drinks from the fridge. -Grabbed a stack of plastic cups and poured multiple juices and set them on the tray of drinks. -Put the tray of drinks back in the fridge and covered them with another tray. -Grabbed dessert cups by the rim and scooped a	F 812		

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F 812	Continued From page 42 blueberry dessert into them. -Grabbed an individual butter condiment from a container full of butter condiments and placed it on a plate of mashed potatoes and roast beef and served that plated food to a resident. -Grabbed a package of crackers from a container full of packaged crackers and placed it on a plate along with a soup spoon he retrieved from a container of soup spoons and served those items to a resident. -Opened a cupboard in the kitchenette and pulled out a cup and lid. -Opened a single-serve ice cream for a resident. -Placed plastic wrap on top of juices and desserts for resident room meal trays. *Dietary manager L prepared a resident's plate while wearing gloves, removed the gloves, and served the plate of food to the resident without washing his hands. *Dietary manager L put on one glove, served a plate of food to a resident, removed the glove and did not wash his hands. 6. Observation on 2/25/25 at 12:57 p.m. of the refrigerator labeled "Drink Fridge" in the main dining room revealed: *The temperature monitoring sheet had several slots with no temperatures recorded. *Those unrecorded temperatures included the AM and PM slot on 2/21/25 and the PM slot from 2/22/25 through 2/24/25. 7. Observation on 2/26/25 at 1:25 p.m. in the activity room kitchenette revealed: *The temperature monitoring sheet on the refrigerator labeled "Snack Fridge" had several unrecorded temperatures including: -The PM slot from 2/4/25 through 2/25/25. -The AM slot on 2/6/25, 2/7/25, 2/13/25, 2/14/25,	F 812		

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 812	Continued From page 43 2/20/25, and 2/21/25. *In the snack fridge, there were several containers of what looked like chocolate pudding that had been scooped into individual plastic serving cups. -There was no label that identified what it was. -There was no date that indicated when it was dished. *In the closet, there were at least three cases of sugar-free chocolate and vanilla pudding with a best if used by date of 1/13/25. *The hot-holding steam table a buildup of rust, food crumbs, and dead flies in the basins. It was not used during the survey. *There was a damp rag balled up in the sink that had a foul odor coming from it. There were no detergent or sanitizer buckets to store the rag in. 8. Interview on 2/27/25 at 9:23 a.m. with FANS cook Q revealed: *There were cleaning checklists designated for each position and shift. -She indicated that the checklists were not used that often. -She did not know where the completed checklists were supposed to have been turned in. *She thought that one of the other cooks delimed the dishwasher every Saturday. *The person who put the groceries away was supposed to go through the cooler and freezer and discard the old and expired foods. 9. Continued observations on 2/27/25 at 9:38 a.m. in the walk-in cooler revealed: *A box of ground beef and a crate of four gallons of milk sitting directly on the floor. *A sheet pan of breadsticks that were not covered, labeled, or dated.	F 812		

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F 812	Continued From page 44 10. Interview on 2/27/25 at 9:56 a.m. with executive director I revealed: *He was new to his position as of the previous week. *He was not aware of the above observed dietary department concerns. *He agreed that the issues needed to be addressed. 11. Observation on 2/27/25 at 1:51 in the main dining room kitchenette revealed: *The missing temperatures from the "drink fridge" temperature monitoring sheet were now all filled out. *A jar of peanut butter on the shelves above the steam table had a manufacturer's best by date of 12/28/24. *An unnamed refrigerator contained the following expired foods: -Eight chocolate pudding cups with best by dates of 1/13/25. -Two cartons of decaffeinated coffee concentrate for the coffee dispenser with a manufacturer's code of "Consume Before Jan 28 2025." *There were two bottles of unopened mustard in the cupboards with a best by date of 5/24/24. *There was a small fan in the cupboard above the serving line that was covered in dust. *There was a container of "Prairie Farms Sour Cream" on the counter that had "Thickener 2-28" written on it. -There was white powder on the inside which appeared to be powdered food thickener. -The scoop was sitting in the thickener. -There were no directions included with the packaging of how to use the food thickener, or how many scoops were required for the different thickness levels. *There was another clear plastic container that	F 812		

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F 812	Continued From page 45 was labeled "9-29 Thickener." -The scoop was sitting in the thickener. -There were no directions on that container. *The space beneath the steam table was very rusty and had food crumbs and scrambled eggs scattered throughout. An electric flattop griddle and a perforated steam pan were stored in that space. *The particle board under the sink had completely disintegrated, leaving behind a mound of black, damp, musty-smelling powdered wood and exposed sub-floor. 12. Follow-up interviews with dietary manager L were attempted on 2/27/25, but he was not available. 13. Review of the provider's October 2017 Food Storage policy revealed: *"Policy Statement: Food storage areas are maintained in a clean, safe, and sanitary environment." *"Procedure: -1. Food storage areas are kept clean at all times. -2. ...Packaged food, canned foods, or food items stored are kept clean and dry. -3. Dry, bulk foods, (flour, sugar, dry beans, food thickener, spices, etc.) are stored in seamless metal or plastic containers with tight fitting covers or in bins that are easily sanitized. It is recommended that foods in bins (e.g. flour or sugar) be removed from original packaging. Scoops are not stored in direct contact with food. Do not add more product to a bin container until it is empty and sanitized. -4. ...Empty food cans are not reused. -5. Foods are dated with month and year of delivery to the Center ... -6. Food products are used within one year	F 812		

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F 812	Continued From page 46 unless the manufacturer's expiration date is different. - ...9. Foods stored in walk-in refrigerators and freezers are stored above the floor on shelves, racks, dollies, or other surfaces to facilitate thorough cleaning ... -10. Opened items have 'use by' dates indicated on them. This 'use by' date may be circled to differentiate it from date received or date opened. May indicate date opened or date prepared if required by your survey agency. -11. The manufacturer's expiration date, when available, is the use by date for unopened items. -12. ...thawing meats are stored in the refrigerator, preferably on the bottom shelf. Do not store them over ready to eat foods." 14. Review of the provider's December 2021 Glove Use policy revealed: *"Policy Statement: Gloves are worn to maintain safe and sanitary food preparation and service." *"Procedure: -1. Proper utensils are used for food handling. -2. Bare hand food contact is prohibited. -3. Proper use of gloves: --a. Wash hands thoroughly before and after wearing or changing gloves. Bacteria build up under gloves and are washed away after wearing gloves. --b. Use gloves that fit properly and that are designed for the task being performed. --c. Change gloves periodically to minimize the buildup of perspiration and bacteria. --d. Gloves are single use and thrown away after each task. Change gloves whenever leaving the workstation or changing the type of food being prepared. --e. Change gloves and wash hands after sneezing, coughing, or touching your hair or face	F 812	1. The deficient findings from this 2567 were corrected. 2. All expired, unlabeled foods, perished food was discarded. The floors were cleaned. 3. The Regional Dietician and Dietary Manager have reviewed the Dish machine procedures, Kitchen cleaning/ sanitation, Food labeling and storage and refrigerator temperatures policies. Regional Dietician and Dietary Manager will educate all dietary staff on the above policies/procedures by 3/21/25. All dietary staff not in attendance will be educated prior to their next shift worked 4. The Dietary Manager or designee will audit audit food labeling and storage, kitchen cleaning logs, refrigerator temps and food expiration dates weekly X4 weeks and monthly X2 months. Dining room monitoring will be conducted by the Administrator or designee 3-5 times weekly X1 month, weekly X2 months. The Dietary Manager, or designee will bring the audit findings to the monthly QAPI committee for further review and recommendations on continuing or discontinuing the audits.	3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 47 with gloved hands. --f. Avoid wearing gloves whenever their use presents a potential safety hazard (near hot equipment where melting may occur, etc.). --g. All foods on tray line are served out with utensils, no bare hand contact." 15. Review of the provider's July 2008 Refrigerator and Freezer Temperatures policy revealed: *"Procedure: - ...2. Refrigerator/Freezer temperatures are recorded twice a day, once in the morning and once in the evening."	F 812		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 865	Continued From page 48 Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership.	F 865		

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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F 865	Continued From page 49 The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify	F 865		

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F 865	Continued From page 50 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interviews, and quality assurance and performance improvement (QAPI) plan policy review, the provider failed to ensure they identified and corrected quality deficiencies when they occurred throughout the facility and that performance improvement projects (PIP) had been thoroughly identified, implemented, monitored, and regarding pressure ulcer prevention and treatment, infection control including enhanced barrier precautions, and pain management. Findings include: 1. Review of the provider's current QAPI PIPs included: -Maintenance projects. -Dietary cleaning, labeling, and dating. -QAPI. 2. Interview on 2/27/25 at 12:58 p.m. with medical director (MD) H revealed: *He was aware some residents had pressure ulcers. *He completed rounds once a month. -He was updated on pressure ulcers during rounds. *His Nurse practitioner would complete rounds opposite of his rounds schedule. -She received information via fax regarding resident skin issues. *He did not know all the details about the facility and their processes. *He attended the facility's QAPI meetings. -He did not create a QAPI plans. -He provided his insight to the facility QAPI team. *He felt the facility's QAPI had improved within	F 865		

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F 865	Continued From page 51 the last month and that it was not a priority before. *He observed wounds when he saw the residents. *He was not aware the facility did not have a repositioning policy. *He wanted the residents to have high-quality care. 3. Interview on 2/27/25 at 1:43 p.m. with the director of nursing (DON) A revealed: *She was the QAPI advisor. *Areas considered for quality improvement opportunities per the QAPI plan included: -Areas needing systemic changes. -Cross-departmental issues. -Evidence-based practices. -Issues that require environmental changes. -Issues affecting staff satisfaction and safety. *Adverse events were monitored by the QAPI team having identified patterns regarding falls and staff who had worked when those events occurred. -They had started a PIP and completed audits to monitor those events. *QAPI was updated in January 2025. *QAPI training had been assigned to staff. -QAPI training was completed by 56 out of 59 of those staff who were assigned that training. *Regarding so few staff attending Interdisciplinary team (IDT) meetings for resident care updates: *Departments should attend to give input into resident care improvement these include: -Nursing department. -Activities department. -Social service department. -Dietary department. -Therapy department. -MDS Coordinator.	F 865		

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F 865	Continued From page 52 *IDT meetings were scheduled by social service, quarterly, annually and with significant change in resident condition. -Invites were sent to all department heads. -Things would come up and they would not attend. -There had been discussion about more people needing to be in attendance. *She was aware infection control, wound care, and enhanced barrier precautions (EBP) all needed improvement. *Feeding assistance was discussed with her, and she agreed improvement was needed. *Building Environment regarding maintenance PIP still needs much improvement: -Missing ceiling tiles in resident bathroom. -Uncleanable surfaces on shower chairs. -Missing flooring in the therapy rooms. -Equipment in therapy being dirty and unclean. Review of the provider's March 2024 QAPI plan policy revealed: *"QAPI is a dynamic process used to facilitate identification of areas for improvement and to drive quality of care and services. The Quality Assurance (QAA) Committee oversees the Center QAPI program. They are tasked with identifying areas requiring performance improvement, collecting data, developing and implementing corrective action, and creating monitors to determine and validate changes are effective and sustained." *"QAA Committee is responsible for collecting and reviewing data from various sources. These include but are not limited to; the Center Assessment, data derived from Center quality management program (Abaqis) activities, input and suggestions from staff,	F 865		

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F 865	Continued From page 53 residents and other internal and external stakeholders. When performance indicators deviate from expected or benchmarked performance the QAA Committee will prioritize opportunities for improvement and determine the appropriate response including specialized workgroups." *"Workgroups are initiated to focus on high-risk, high-volume, or problem-prone areas. Consideration is given to the incidence, prevalence, and the severity of the problem; affect to health outcomes, resident safety, resident autonomy, resident choice, and quality of care. Workgroups address process improvement through corrective action plans and Plan, Do, Study, Act (PDSA) rapid improvement cycle model." *"The QAA committee may determine that some concerns are limited in scope and may be effectively corrected through simple process adjustments. These are "quick fix" items that do not warrant Workgroup or subcommittee development." *"The QAPI Plan and revisions are communicated to the governing body, staff, residents and family members with appropriate communication tools. Examples may include a designated QAPI bulletin board for staff, residents and family members, discussion of QAPI activities during all staff meetings and the provision of routine reports to our governing body." *"QAA Committee identifies opportunities for improvement: -QAA Committee evaluates ongoing effectiveness of Performance Improvement Plan (PIP). -QAA Committee sets timetable for follow-up review, if necessary.	F 865	1. The deficient findings from this 2567 were reviewed by the QAPI Committee. 2. Issues identified in the 2567 were resolved by the compliance date. An ad-HOC QAPI was completed 3. The Administrator and Director of Nursing have reviewed the QAPI Policy and have educated the Interdisciplinary Team on policy on 3/25/2025. 4. The Regional Director of Clinical will review QAPI monthly monthly X3 months. The Administrator designee will bring the audit findings to the monthly QAPI committee for further review and recommendations on continuing or discontinuing the audits.	3/27/2025

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F 865	Continued From page 54 -QAA Committee determines duration of continued monitoring for sustained improvement. -QAA repeats/returns to PDSA if sustained improvement is not achieved."	F 865		
F 880 SS=E	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 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		

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F 880	Continued From page 55 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 infection control and prevention practices were followed relating to: *One of one registered nurse (RN) (B) who	F 880		

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F 880	Continued From page 56 provided wound care treatments for five of seven sampled residents (109, 42, 28, 24, and 10) with ordered wound care treatments. *Two of three certified nursing assistants (CNA) (T, U, and V) who provided direct patient care and catheter care for two of two sampled residents (12 and 109). *Resident care equipment cleanliness in the therapy gym and the whirlpool tub located on the first floor. Findings include: 1. Observation and interview on 2/26/25 at 7:39 a.m. with RN B during resident 109's wound care treatment revealed: *There was no sign that indicated staff needed to use enhanced barrier precautions (EBP) or personal protective equipment (PPE) while providing his care posted outside or inside his room. *She had two adhesive dressings and a hydrocolloid patch (wound healing product) with the date labeled on them laying on a treatment cart. *She performed hand hygiene (HH) with hand sanitizer, applied gloves, picked up the dressings and entered the resident's room. *Resident 109 gave his permission to be observed. *Resident 109 was completely uncovered sitting on a bath chair while CNA T attached a full body mechanical lift (a mechanical lift and sling used to lift a person's full body) and transferred him to the bed. *CNA T was wearing gloves and no other PPE. *While resident 109 was lying in bed, RN B: -Removed the soiled dressing from resident 109's right ankle and discarded it in the garbage can. -Removed her gloves, discarded them into the	F 880		

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F 880	Continued From page 57 garbage can, and applied new gloves without performing HH. -Without cleaning the wound, she applied a new adhesive dressing to his right ankle wound. -Removed her gloves, discarded them into the garbage can, and applied new gloves without performing HH. -Removed the soiled hydrocolloid patch from his second toe on his right foot. -Without cleaning the wound, she applied a new hydrocolloid patch to his stage two pressure ulcer (wound with partial thickness skin tissue loss from prolonged pressure). -Removed her gloves, discarded them into the garbage can, and applied new gloves without performing HH. -Assisted CNA T in rolling resident onto his side, removed the soiled adhesive dressing from his upper middle back, and without cleaning the wound applied a new adhesive dressing to the abrasion. -Discarded the soiled dressing in the garbage can, removed and discarded her gloves, and performed hand hygiene. *She stated the hydrocolloid patch was a big patch that she had cut into tiny pieces to fit onto his toe. She kept the unused patch pieces in the opened patch package in the treatment cart. 2. Observation and interview on 2/26/25 at 7:55 a.m. with RN B while providing resident 42's wound care treatment revealed: *She performed HH, retrieved her wound care and suprapubic catheter (a flexible tubing surgically placed through the abdomen to drain urine from the bladder) care supplies (dressings) from the treatment cart, entered the resident's room, and placed the dressing packages on the bed sheet without a barrier under them next to	F 880		

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F 880	Continued From page 58	F 880		

the resident.
*Resident 42 gave his permission to be observed.
*RN B put on a gown, mask, and gloves.
*She wet a washcloth in the bathroom and placed it on the bed sheet next to the resident along with wet wipes and a skin barrier cream.
*After she removed the resident's undergarments, she:
-Removed the suprapubic catheter dressing and wiped around the tubing with a wet washcloth.
-Removed and discarded her gloves into a garbage can and put on new gloves without performing HH.
-Opened the suprapubic catheter dressing, set it on the bed sheet, applied the barrier cream on the resident's skin, and applied the dressing.
-Removed and discarded her gloves into garbage can and put on new gloves without performing HH.
-Opened the adhesive dressing (to be placed on resident's coccyx (tailbone)), pulled it out of the package and set it on the bed sheet.
-Labeled the adhesive dressing and put on new gloves without performing HH.
-Helped roll the resident onto his side.
-Removed the soiled dressing from the resident's coccyx.
-Wiped the area with the wet wipes lying on the bed.
-Removed and discarded her gloves into the garbage can and put on new gloves without performing HH.
-Applied the barrier cream and new patch to his coccyx.
*RN B was not aware of the areas underneath his scrotum (skin pouch under the penis) had opened and stated they had been putting a barrier cream on it.
*RN B then applied a barrier cream to those open

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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F 880	Continued From page 59 areas. *While performing wound care for his colostomy bag she: -Laid paper towels down onto the resident's lap and placed a black plastic bag on top of them. -Set scissors, wet wipes, a colostomy bag, skin paste, powder, and colostomy adhesive wafer onto the bed sheet without having placed a barrier under those supplies. -Removed the used colostomy bag and cleaned the opening with wet wipes. -Removed and discarded her gloves into the garbage can and put on new gloves without performing HH. -Opened a skin prep wipe and wiped the skin around the colostomy opening. -Applied the powder to the skin, set the powder in the black plastic bag. Resident 42 asked her if it was empty, to which she said, "No" and removed it from the bag and set it back on the bed sheet. -Measured the colostomy opening, cut the new colostomy adhesive wafer, set it back on the bed, applied the skin paste, applied the wafer to the skin, and attached the new colostomy bag to the wafer. -Discarded the used supplies, set the powder and skin paste on the resident's tray table, removed her PPE, grabbed the powder and skin paste, and exited the room without performing HH. 3. Observation on 2/26/25 at 8:30 a.m. of RN B during resident 28's wound care treatment revealed: *There was signage on his door that he was on EBP and the staff should have worn gloves, gown, and a mask. *She had a medication cup containing a small amount of white cream and a pair of gloves that had been lying on the treatment cart.	F 880		

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

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F 880	Continued From page 60 *She took those supplies to resident 28's room. *The resident was on EBP, and that required her to put on PPE prior to entering his room. *She placed the medication cup and gloves on the siderail located outside of the resident's room while she put on the PPE. *She put on those gloves and was not observed to have sanitized her hands before she put them on. *With those gloved hands she: -Opened the resident's door and placed the medication cup on the resident's bedside dresser without a barrier under the medication cup. *She had forgotten to put on a mask and had to leave the room to get one. *Without removing her gloves, she opened the door, got a mask, and put it on her face. *She entered the resident's room, and with those same gloved hands she: -Grabbed a package of wet wipes from the resident's roommate's bedside table. -Removed the bed covers off the resident and assisted him with rolling over to his right side. -Exposed and cleansed his bottom area with a wet wipe. -Removed the cream from the medication cup and applied to his bottom and coccyx area. *She removed her gloves and then washed her hands. 4. Observation on 2/26/25 at 11:30 a.m. of RN B during resident 24's wound care treatment revealed: *She removed several supplies from the treatment cart and placed them on top of the treatment cart without a barrier under them including: -Several gauze dressings she had been taken out of a bulk package.	F 880		

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

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F 880	Continued From page 61 -A bottle of wound cleanser and several gloves. -A pair of scissors and a protective dressing. *She gathered those supplies. took them to the resident's room, and laid them on his bed covers without a barrier under them. *The resident was seated in his wheelchair. *She placed a disposable pad underneath his right foot. *On his door he had signage that he was on EBP and required the staff to use PPE when caring for him. *She sanitized her hands prior to putting on gloves, gown, and a mask. -She put on a pair of gloves that had been lying on resident 24's bedcovers. *She: -Removed his sock and ace bandage from his right foot/leg. -Removed a protective dressing from his right ankle. The dressing had a moderate amount of serous sanguineous drainage on it. *The resident had an open wound and a scabbed wound in that area. *She: -Removed her gloves, sanitized her hands, and put on another pair of gloves that had been lying on the resident's bedcovers. -Took the bottle of wound cleanser and moistened the opened gauze that had been lying on top of a dressing package. -Cleansed his wounds with that same gauze. -Took off the gloves and without sanitizing her hands, put on another pair of gloves that had been laying on his bedcovers. -Opened a package that contained a medicated dressing, cut it with the scissors laying on the resident's bedcovers, moistened it with a syringe of saline that was lying on the resident's bedcovers.	F 880		

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	435086	A. BUILDING _____ B. WING _____	C 02/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 62 -Placed that dressing on a foam bordered dressing, and applied it to the wounds on the his ankle. -Removed her gloves, washed her hands, removed her gown and mask, gathered up the rest of the supplies, and placed them on the treatment cart. -Opened the cart and placed the unused pieces of gauze back into the bulk package that contained clean gauze. 5. Interview on 2/26/25 at 11:25 a.m. with RN B regarding the observations above revealed: *There was no designated wound care nurse. *Whomever was assigned on the schedule for that day was responsible for providing the resident's wound care. *She had not had any training on wound care and could not recall having wound care competencies completed. *She: -Confirmed the steps observed above was her usual process for completing the resident's sound care. -Had not considered that process to be wrong or that it could have created the potential for the residents to acquire an infection. *She then agreed her wound care process did not follow appropriate infection control practices and could have created the potential for infection and may have interfered with the wound's healing process. 6. Observation on 2/27/25 at 7:18 a.m. with RN B during resident 10's wound care treatment revealed: *She applied a gown, mask, and gloves. *There was a barrier placed on the resident's tray table with a bottle of hand sanitizer, two unpacked	F 880		

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F 880	Continued From page 63 and dated adhesive dressings, a bottle of skin cleanser, Vaseline in a plastic cup, and unpacked gauze. *She removed a box of gloves from the wall organizer and placed it onto the barrier with the wound care supplies. *Resident 10 gave his permission to be observed. *After performing HH she: -Applied gloves, placed a barrier under both of his feet, removed the resident's left sock and soiled dressing. -Discarded her gloves in the garbage can, performed HH, and put on new gloves. -Sprayed the skin cleanser on a piece of gauze, lifted the resident's left heel, dabbed it with the gauze, and set the left heel on his other foot. -Discarded her gloves in the garbage can, performed HH, and put on new gloves. -Lifted the resident's left heel, applied Vaseline, a new dressing, and placed his sock back on. -Discarded her gloves in the garbage can, performed HH, and put on new gloves. -Removed the resident's right sock and soiled dressing. -Discarded her gloves in the garbage can, performed HH, and put on new gloves. -Sprayed the skin cleanser on a piece of gauze, lifted the resident's right heel, dabbed it with the gauze, and set the right heel down on the barrier. -Discarded her gloves in the garbage can, performed HH, and put on new gloves. -Lifted the right heel, applied the Vaseline and a new dressing, and his sock. She then removed the barrier from under the resident's feet. -Discarded the extra gauze, removed her PPE, performed HH, gathered the hand sanitizer, wound cleanser, and box of gloves off of the barrier they were on and set them on the treatment cart.	F 880		

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F 880	Continued From page 64 *RN B stated she forgot about his abrasion on his coccyx so she would treat that next. *She set a barrier on the tray table, then set the skin cleanser, bottle of hand sanitizer, gauze, and a folded-up barrier on the barrier. *She removed a barrier cream from the treatment cart and placed some of it into a plastic cup, set it on the barrier. *She removed an unopened adhesive dressing from the treatment cart and set it on the barrier. *She removed the adhesive dressing from the package and labeled it with a marker. *After she performed HH, she: -Applied a gown, mask, and gloves, and set the box of gloves from the treatment cart on the barrier. -Lowered the head of the resident's bed, assisted him to roll onto his side, discarded her gloves into the garbage can, performed HH, and put on new gloves. -Removed the resident's incontinence brief and soiled bandage. -Discarded her gloves into the garbage can, set the barrier on the bed and the bottle of skin cleanser and gauze on top of it. -Performed HH and put on new gloves. -Sprayed the skin cleanser on a piece of gauze, dabbed the resident's wound, then removed and discarded her gloves. -Grabbed the new adhesive dressing and barrier cream and set them on the barrier on the bed. -Performed HH and put on new gloves. -Applied the barrier cream, wiped off excess cream from her gloved hands onto the resident's incontinence brief and applied the new dressing to his coccyx. -With those same gloves, she grabbed the skin cleanser bottle, set it on the barrier on the tray table, re-applied the resident's incontinence brief,	F 880		

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F 880	Continued From page 65 and assisted the resident onto his back. -Discarded her gloves in the garbage, performed HH, and put on new gloves, helped the resident reposition and lifted the head of the bed back up. -Removed her PPE, performed HH, grabbed the skin cleanser and box of gloves and set them on the treatment cart. 7. Interview on 2/27/25 immediately following that wound care treatment with RN B revealed: *She would use EBP with residents who had wounds and catheters. *She agreed she should have been using EBP with resident 109 during his wound care treatment. *She agreed she did not perform appropriate HH or infection control practices during her wound care treatments that she provided to residents 109, 42, and 10. 8. Observation on 2/26/25 at 11:20 a.m. with CNAs U and V with resident 12 revealed: *They had prepared to assist resident 12 with her personal cares and to transfer her out of bed. *On her door there had been signage that she was on EBP and the staff had been required to wear gloves, gown, and a mask when assisting her with personal care. *Without sanitizing his hands, CNA U opened the cover of the linen cart and took out several towels. -He placed those clean towels on the handrail outside of the resident's room. *Without sanitizing their hands, they put on gloves, gown, and a mask and entered resident 12's room. *Resident 12 had been awake and lying on her bed. *CNA U placed the towels inside of the resident's	F 880		

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F 880	Continued From page 66 sink, turned the water faucet on to moisten the towels and applied cleansing body soap on them. *With those same gloved hands CNA U: -Opened the resident's clothes closet, took out two hanging clothes items, and showed them to the resident for approval. *They had moved the resident's bed, her bedside table, and the mechanical lift. *With those same gloved hands CNA U: -Turned off the water faucet and took the wet towels out of the sink. -Placed them on the bedside table and assisted CNA V with removing the resident's incontinent brief and repositioning her. -Took the towels from the bedside table and washed underneath of the resident's abdominal folds. -Used those same towels to cleanse her perineal area and catheter tubing. -He assisted CNA V in moving the resident to her left side and used those same towels to cleanse her bottom. He then cleaned the catheter tubing again with those same towels. -Assisted CNA V with putting on a clean incontinent brief on resident 12 and rolling her to her back. *The Hoyer (mechanical lift and sling used to move a person's full body) lift. sling was too small and he stated he had to leave the room to get a different one. *He then removed the PPE and left the room without sanitizing his hands. 9. Interview on 2/26/25 at 12:30 p.m. with CNA U regarding the observation above with resident 12 revealed: *That had been his usual process for gathering supplies, putting on PPE, and assisting her with her personal hygiene and catheter care.	F 880		

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F 880	Continued From page 67 *He then agreed those practices created the potential for the resident to acquire a urinary tract infection. *He could not recall having had any education or competencies completed for performing appropriate residents' personal hygiene needs. 10. Observations throughout the building on 2/26/25 from 9:04 a.m. to 9:25 a.m. revealed: *In the whirlpool tub room on the first floor: -The rubber bumpers on the whirlpool tub chair were corroded and crumbling apart. It was not a cleanable surface. -There was a buildup of an unidentified brown and yellow substance in the whirlpool tub where the door sealed with the tub. -In one of the drawers in the tub room, there was a scattered variety of soiled hair picks, a gait belt, nail clippers, and fingernail brushes. *In the therapy gym: -There was a buildup of dust, dirt, and unidentified white flakes in the footwells of the NuStep exercise machine. -Resistance bands were tied to the foot pedals on the NuStep exercise machine. -Interview at that time with physical therapist assistant (PTA) Y revealed the physical therapist would sometimes use the resistance bands to strap the resident's feet in place on the NuStep exercise machine. She was unsure how often the resistance bands were cleaned. -Some of the dumbbells were rusted, which were uncleanable surfaces. -PTA Y indicated that they clean the therapy equipment in between each resident use with sanitizing wipes, and the housekeeping staff were responsible for deep cleaning the therapy equipment daily.	F 880		

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F 880	Continued From page 68 11. Interview on 2/27/25 at 9:25 a.m. and 12:27 p.m. with director of nursing (DON) A revealed: *She confirmed she was the infection preventionist. *She had not completed competencies on wound care, perineal care, and catheter care. -That had been one of her future goals. *She would have expected: -The staff to sanitize with each glove change and between tasks. -A barrier to have been used underneath all wound supplies taken into the residents' rooms. -Staff to wear PPE during all direct care activities with residents who were on EBP which included bathing, using mechanical body lifts, and wound care. *She confirmed objects such as handrails, bedcovers, the inside of sinks, bedside tables and dressers were all unclean surfaces. *She was not aware the staff had been placing unused gauze from dressing changes back in the bulk package with clean ones. -The expectation was that they were to have been thrown away. *She had last provided staff education on EBP on 9/25/24. *She confirmed resident 109 had not been on EBP, but he should have been. *She felt all staff could use more education on infection prevention. *She has not observed her nurses performing wound care to view their wound care processes and infection control practices. 12. Interview on 2/27/25 at 1:55 p.m. with district housekeeping manager BB revealed that the housekeeping staff were responsible for sweeping and mopping the therapy room daily, but the housekeeping staff did not deep clean the therapy gym equipment.	F 880		

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F 880	Continued From page 69 13. Review of the provider's revised 4/26/24 Enhanced Barrier Precautions policy revealed: *"1) Enhanced Barrier Precautions (EBP) are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing." *"2) EBP are indicated for residents with any of the following: -b) Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. -d) Chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. -e) Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies." *"6) Enhanced Barrier Precautions requires use of gown and gloves during high contact resident care activities that have been demonstrated to result in transfer of MDROs to hand and clothing of healthcare personnel." *"7) Enhanced Barrier Precautions is primarily intended to apply to care that occurs within a resident's room where high-contact resident care activities, including transfers, are bundled together with other high contact activity, such as part of morning or evening care." *"12) for residents for whom EBP are indicated, EMP is employed when performing the following high-contact resident care activities: -a) Dressing -b) Bathing/showering -c) Transferring -d) Providing hygiene -e) Changing linens	F 880		

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F 880	Continued From page 70 -f) Changing briefs or assisting with toileting -g) Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator -h) Wound care: any skin opening requiring a dressing -i) Therapy activities" *"14) When Enhanced Barrier Precautions are implemented, the Infection Preventionist or designee: -a) Validates protective equipment (i.e., gloves, gowns, masks, etc.) is maintained near the resident's room so that everyone entering the room can access what they need. -b) Posts the appropriate notice on the room entrance door and in the front of the residents' chart so that all personnel will be aware of precautions or be aware that they must first see a nurse to obtain additional information about the situation before entering the room." 14. Review of the provider's updated 4/2018 Handwashing/Hand Hygiene policy revealed: *"7. Use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: -b. Before and after direct contact with residents; -c. Before preparing or handling medications; -d. Before performing any non-surgical invasive procedures; -e. Before and after handling an invasive device (e.g. urinary catheters, IV access sites); -g. Before handling clean or soiled dressings, gauze pads, etc.; -h. Before moving from a contaminated body site to a clean body site during resident care/ -i. After contact with a resident's intact skin; -k. After handling used dressings, contaminated equipment, etc.;	F 880		

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F 880	Continued From page 71 -l. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; -m. After removing gloves; -n. Before and after entering isolation precaution settings;" *"8. Hand hygiene is the final step after removing and disposing of personal protective equipment." *"9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." 15. Review of the provider's updated 4/2012 Charge Nurse Job Description revealed: *"h. Assesses and reports changes in resident's condition, including development of pressure ulcers, to physician, the DNS and responsible party, and takes recommendations for nursing action to be implemented." *"4. Assesses on a weekly basis via resident rounds the condition of existing pressure ulcer by stage, size (measurements), sites depth, color, drainage, and odor. Reports problems to the DNS; takes necessary follow up action." *"9. Observes infection control procedures performed by staff to validate compliance." 16. Review of the provider's updated 4/2012 Director of Nursing Services Job Description revealed: *"3. Establishes systems for care planning, including assessments, plan of treatment, objectives and goals, evaluations, and discharge planning. Maintains accurate and timely documentation reflecting same. Coordinates care needs with other departments." *"5. Responsible for recruiting, interviewing,	F 880	1. Resident #109 is no longer residing in the facility. Resident #42, #28, #24 and #10 were all placed on enhanced barrier precautions. 2. All residents were reviewed for criteria related to enhanced barrier precautions. Deficient findings were corrected. 3. The facility has assigned a wound care nurse. The Director of Nursing and Interdisciplinary Team have reviewed the following policies: -Enhanced Barrier Precautions -Catheter Care -Colostomy Care -Hand Washing -Donning and Doffing PPE Nursing staff will be educated on the above policies by 3/27/25. All staff not in attendance will be educated prior to their next shift worked. 4. The Director of Nursing or designee will audit enhanced barrier precautions, catheter care, colostomy care and hand washing. These audits will be completed weekly X4 weeks and monthly X2 months. The Director of Nursing or designee will bring the audit findings to the monthly QAPI committee for further review and recommendations on continuing or discontinuing the audits.	3/27/2025

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F 880	Continued From page 72 hiring, disciplining, coaching, and conducting performance appraisals on assigned units, or delegating to the appropriate individuals. Confers with ED prior to termination of subordinate staff."	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the walk-in cooler and freezer in a functioning manner that met industry standards. Findings include: 1. Observation and interview on 2/25/25 from 8:28 a.m. to 9:09 a.m. in the kitchen with dietary manager L revealed: *Upon walking into the walk-in cooler and shutting the door, the light from the hallway was clearly visible above the top of the door, indicating the door did not seal properly. -The gap was large enough to poke several fingers through. -There was an abundance of an unidentified black and white fuzzy growth on the walls, door frame, floor, and shelving units that appeared to have been mold. Mold growth in a walk-in cooler could potentially be due to improper temperature control. *There was ice buildup on the ceiling and floor of the walk-in freezer, which indicated improper temperature control. -At the time of the observation, a side panel of the condenser was hanging and not secured to the condenser unit. The condenser was blowing hot	F 908		

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F 908	Continued From page 73 air, which was melting the ice buildup on the ceiling and floor. *Interview at that time with dietary manager L revealed that he was aware of the issues in the walk-in cooler and freezer. 2. Follow-up interviews with dietary manager L were attempted on 2/27/25, but he was not available.	F 908	1. Items listed in the 2567 were repaired. 2. Environmental rounds were conducted by the Administrator and the Director of Building Plant and Safety to identify other deficient findings. Deficient findings were fixed. 3. The Preventative Maintenance Policy was reviewed by the Administrator. The Maintenance Director and Dietary Manager will be educated on the policy by 3/27/25. 4. Administrator or designee will conduct a Food and Nutrition Inspection 3 times weekly for one month, then weekly for one month. The Administrator or designee will bring the audit findings to the monthly QAPI committee for further review and recommendations on continuing or discontinuing the audits.	3/27/2025

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E 000	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 2/26/25. Riverview Healthcare Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at E004 and E039 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:	E 004	All residents have he potential to be affected. The Executive Director updated the Emergency Preparedness Plan (EPP) on 03/28/25. The ED or designee will audit the EPP weekly times 1 month and monthly times 2 months to ensure updates to the EPP is up to date. The ED or designee will bring the audits to the monthly QAPI for review and recommendations to continue or discontinue the audits.	03/28/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	03/23/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING _____ B. WING _____	02/26/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004	Continued From page 1 * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to update the emergency preparedness plan annually. Findings include: 1. Record review on 2/26/25 at 10:45 a.m. revealed no documentation that indicated the provider's current emergency preparedness plan was updated annually. Interview with the administrator on 2/26/25 at 11:30 a.m. confirmed that finding.	E 004		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2)	E 039	All residents have the potential to be affected. (continued)	03/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
E 039	Continued From page 2 §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039	(continued from page 2) The Executive Director submitted a membership form with the South Dakota Health Care Coalition (SDHCC) on 03/23/25. The facility will participate in an annual full-scale exercise that is community based with the SDHCC in 2025. When a community-based exercise is not accessible, the facility will conduct an annual individual, facility-based functional exercise in 2025. The Executive Director will contact the Moody County Emergency Manager, Jerrick Charles to determine if any community based exercised are planned for 2025. The ED or designee will conduct an additional annual exercise that will include a tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan on 03/28/25 The ED or designee will conduct audits of the EPP weekly times 1 month and monthly times 2 months. The ED or designee will bring results of the audits to the monthly QAPI for review or recommendation to continue or discontinue the audits.	

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RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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E 039	Continued From page 3 a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using	E 039		

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	435086	A. BUILDING _____ B. WING _____	02/26/2025

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E 039	Continued From page 4 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.	E 039		

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E 039	Continued From page 5 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]	E 039		

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E 039	Continued From page 6 (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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E 039	Continued From page 7 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that	E 039		

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E 039	Continued From page 8 is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.	E 039		

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E 039	Continued From page 9 (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared	E 039		

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E 039	Continued From page 10 questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to conduct an exercise for emergency preparedness in 2024. Findings include: 1. Record review on 2/26/25 at 10:45 a.m. revealed no documentation that indicated any exercises were conducted to test the provider's emergency plan for 2024. Interview with the administrator on 2/26/25 at	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 11 11:30 a.m. confirmed that finding.	E 039		

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	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 2/26/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Riverview Healthcare Center Building 1 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 K100, K211, K222, K271, K321, K353, K363, K712, K918, and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 100 SS=D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain a smoke-tight ceiling at one randomly observed location (shared toilet room for resident rooms 17 and 19). Findings include: 1. Observation beginning on 2/26/25 at 8:45 a.m. revealed the ceiling in the toilet room shared between resident rooms 17 and 19 had approximately four square feet of the ceiling missing. Interview at the time of the observation with the maintenance director confirmed that	K 100	All residents have the potential to be affected. On 03/05/25 contractor Hanson Thomas Construction removed the expanded metal to eliminate the possibility of from falling. A drop ceiling was installed to the appropriate height to enable the sprinkler system to function properly. The ED or designee will inspect all resident bathrooms to ensure ceilings are intact weekly times 4 weeks and monthly times 2 months. The ED or designee will bring the results of these audits to the monthly QAPI meeting for review and recommendation to continue or discontinue the audits	03/28/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	03/23/25

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

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K 100	Continued From page 1 condition. He stated there had been a pipe leak above the ceiling that required its removal to repair the leak. The missing ceiling would not allow heat to build up and activate the sprinkler in the toilet room as designed. The heat would escape into the ceiling joist area. The deficiency affected 100% of the smoke compartment occupants.	K 100		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, testing, review, and interview, the provider failed to maintain egress free from obstructions at one of eight EXIT locations (lower level west wing EXIT). Findings include: 1. Observation and testing on 2/26/25 at 8:30 a.m. of the lower-level west EXIT door revealed the door would not completely open. By applying greater than fifty pounds of force in the direction of the path of egress revealed that door only opened 24 inches and could not be opened any further. Review of the previous survey dated 2/13/24 revealed that condition existed at that time.	K 211	All residents have the potential to be affected. The door was adjusted to allow proper operation in the direction of the path of egress to allow the door to fully open on 03/20/25. ED educated the Maintenance Supervisor on Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, NFPA 101 on 03/23/25. The ED or designee will audit egress doors to ensure they opens fully by applying less than fifty pounds of force in the direction of the path of egress weekly times 1 month and monthly times 2 months. The ED or designee will bring the results of these audits to the monthly QAPI meeting for review and recommendation to continue or discontinue the audits.	03/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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

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K 211	Continued From page 2 Interview with the maintenance director at the time of the above observations confirmed those conditions. He stated he was aware that door was not able to be opened fully and had been in contact with a local contractor to correct that condition. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.1, 7.2.1.4.5.1(2)	K 211		
K 222 SS=B	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the	K 222	All residents have the potential to be affected. ED or designee will educate Maintenance Director on NFPA Life Safety Code 10, 7.2.1.6.1 Delayed-Egress Locks by 3/28/2025. Stop sign was removed on the lower-level west exit on 02/27/25. Stop sign removed on the south wing exit door on 02/27/25. Stop sign was removed on the north wing exit on 02/27/25. Sign that reads "Push Until Alarm Sounds - Door Can Be Opened In 15 Seconds" was installed on the lower level main exit door on 03/21/25. ED or designee will audit doors with delayed egress locks to ensure that they have appropriate signage in place weekly (continued)	03/28/25

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	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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K 222	Continued From page 3 safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	K 222	(continued from page 3) times 1 month and monthly times 2 months. ED or designee will bring the results of these audits to the monthly QAPI meeting for review and recommendation to continue or discontinue the audits.	

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	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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K 222	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain egress door signage as required at four of nine exit door locations (lower level west wing EXIT, upper level south EXIT, upper level north EXIT to the fire escape, and lower level main entrance). Findings include: 1. Observation on 2/26/25 at 8:30 a.m. revealed the lower-level west EXIT door had a magnetic door lock installed. Testing of the door lock revealed it was a delayed-egress magnetic lock. The door did not have the required delayed egress signage. The door also had an eight-inch by twelve-inch sign stating 'STOP THIS IS NOT AN EXIT'. That STOP sign was removed during the survey. 2. Observation on 2/26/25 at 9:10 a.m. revealed the south wing EXIT door by rooms 130 and 131 had an eight-inch by twelve-inch sign stating 'STOP THIS IS NOT AN EXIT'. That STOP sign was removed during the survey. 3. Observation on 2/26/25 at 9:15 a.m. revealed the north wing EXIT door had an eight-inch by twelve-inch sign stating 'STOP THIS IS NOT AN EXIT' by rooms 122 and 123. That STOP sign was removed during the survey. 4. Observation on 2/26/25 at 9:45 a.m. revealed the lower level main EXIT door had a magnetic door lock installed. Testing of the door lock revealed it was a delayed-egress magnetic lock. The door did not have the required delayed egress signage. Interview at the time of the above observations	K 222		

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	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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K 222	Continued From page 5 with the maintenance director confirmed those conditions. The deficiency affected 100% of the smoke compartment occupants.	K 222		
K 271 SS=C	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the exit discharge for two of five EXIT locations (upper level south EXITS). Findings include: 1. Observation on 2/26/25 at 9:40 a.m. revealed the upper level EXITS from the south wing and nurse's station to the south discharged onto a concrete patio but did not extend to the public way (street). The patio was surrounded by grass. That condition would be a hindrance to egress during inclement weather. Interview with the administrator on 2/26/25 at 11:30 a.m. confirmed that finding. The deficiency had the potential to affect 100 percent of the smoke compartment occupants.	K 271	All residents have the potential to be affected. ED educated Maintenance Director on Life Safety 101, Discharge of Exits 7.1.7 on 03/23/2025. Requesting a waiver to extend the compliance date to 08/26/25 to allow the facility to obtain bids to install a multi-level ADA complaint ramp to the public right-of-way or install new side walks to the public right-of-way.	03/28/25
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321	All residents have the potential to be (continued)	03/28/25

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	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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K 321	Continued From page 6 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 Separation N/A — Automatic Sprinkler a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain two separate hazardous areas (lower level storage room and kitchen pantry storage room) as required. Findings include: 1. Observation on 2/26/25 at 8:50 a.m. revealed the lower level storage room was over 100	K 321	(continued from page 6) affected. ED educated Maintenance Director on Hazardous Areas - Enclosures on 03/23/2025. Door closers were installed on the lower level storage room and kitchen pantry storage door that permit doors to close and latch properly on 03/21/25. ED or designee will audit door closers in lower level storage room and kitchen pantry storage room to ensure operating properly weekly times 1 month and monthly times 2 months. The ED or designee will bring the results of these audits to the monthly QAPI meeting for review and recommendation to continue or discontinue the audits.	

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	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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K 321	Continued From page 7 square feet and contained combustible items. The corridor door would not close and latch with the operation of the closer. 2. Observation on 2/26/25 revealed the kitchen pantry storage room was over 100 square feet and contained combustible items. The pantry door was not equipped with a closer. The pantry was not separated from the egress corridor with a self-closing door. Interview with the maintenance director at the times of the observations confirmed those findings. The deficiency affected two of numerous requirements for hazardous storage rooms.	K 321		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353	All residents have the potential to be affected. ED educated the Maintenance Supervisor on how to complete automatic sprinkler flow tests and record keeping of quarterly flow tests on 03/23/25. Age of sprinkler was determined on 03/20/25. Quarterly sprinkler flow test was completed on 03/21/25. The fire service company is scheduled to test sprinkler heads on 03/26/25. ED or designee will audit logs to ensure quarterly sprinkler tests are completed timely. Audits will be completed monthly times 3 months. The ED or designee will bring the results of these audits to the monthly QAPI (continued)	03/28/25

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	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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K 353	Continued From page 8 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow tests not done and undated standard sprinkler heads). Findings include: 1. Record review on 2/26/25 at 10:10 a.m. revealed no documentation that indicated the required quarterly flow tests had been performed in 2023, 2024, and 2025. Annual sprinkler inspections were completed on 6/1/23 and 6/6/24. A 5-year internal inspection was performed on 6/16/21. 2. Record review on 2/26/25 at 10:15 a.m. revealed no documentation or comments from the sprinkler contractor that stated the age of the standard sprinklers installed in the building and subsequent testing in accordance with NFPA 25. Interview with the maintenance director at the time of the record review confirmed those conditions. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected two of numerous required tests on the automatic sprinkler system.	K 353	(continued from page 8) meeting for review and recommendation to continue or discontinue audits. Requested a waiver to extend the compliance date to 08/26/25 to have our fire service professionals identify the sprinkler heads that are over 50 years of age. allow for lab testing and receive results. If one sprinkler in the test sample fails, all sprinkler heads of that type will be replaced.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than	K 363	All residents have the potential t be affected. ED or designee will educate dietary staff (continued)	03/28/25

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	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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K 363	Continued From page 9 required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the corridor doors without	K 363	(continued from page 9) that doors without a magnetic hold open cannot be propped open to impede closing in case of fire. The wooden wedge was removed from the kitchen corridor door. The ED or designee will audit magnetic hold open door in kitchen corridor to ensure not being propped open weekly times one month and monthly times 2 months. The ED or designee will bring the results of these audits to the monthly QAPI meeting for review and make recommendation to continue or discontinue audits.	

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	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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K 363	Continued From page 10 impediment to closing as required (kitchen door). Findings include: 1. Observation on 2/26/25 at 9:40 a.m. revealed the kitchen corridor door was held open with a wood floor wedge. The door was not equipped with a magnetic hold-open tied into the fire alarm system. Interview with the maintenance director at the time of the observation confirmed that finding. The deficiency had the potential to affect 100 percent of the smoke compartment occupants.	K 363		
K 712 SS=F	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. 19.7.1.4 through 19.7.1.7 This REQUIREMENT 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 procedures (closing corridor doors and checking the door for the fire location). Findings include: 1. Observation of the fire drill conducted on	K 712	All residents have the potential to be affected. The ED or designee will in-service all staff on fire drill procedures. The ED or designee will complete audits to ensure fire drill procedures are performed monthly times 3 months. The ED or designee will bring the results of these audit to the monthly QAPI meeting for review and make recommendations to continue or discontinue audits.	03/28/25

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	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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K 712	Continued From page 11 2/26/25 at 10:30 a.m. revealed the staff member responding to the simulated fire in resident room 109 removed the resident from the room but did not shut the corridor door. That staff member was unsure of the next step to perform and asked the maintenance director for instructions. The staff member could not activate the manual pull device at the nurses' station due to its stiffness. The maintenance director had to activate the fire alarm with the manual pull station. There was no announcement of the simulated fire until three minutes into the fire drill. It was announced while the alarm buzzer was sounding and was very difficult to hear. The staff member who first responded to the simulated fire location with a fire extinguisher did not check the door or the door handle of the room for heat prior to entering the room. Interview with the maintenance director at the time of the observations confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918	All residents have the potential to be affected. Replaced terminal covers on 03/17/2025. Completed battery conductivity test on 03/22/25. Completed load test on 03/22/25. The results of each test were annotated on logs. ED or designee will complete audits of conductivity test and load test weekly times 1 month and monthly times 2 months. (continued)	03/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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K 918	Continued From page 12 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: A. Based on observation and interview, the provider failed to install generator battery terminal covers as required (battery installed in 2024). Findings include: 1. Observation on 2/26/25 at 9:25 a.m. revealed the generator battery did not have terminal covers. Interview with the maintenance director at the time of the observation confirmed that finding. He stated the battery was installed in 2024. The deficiency affected one of numerous requirements for generator maintenance.	K 918	(continued from page 12) The ED or designee will bring the results of these audit to the monthly QAPI meeting for review and make recommendations to continue or discontinue audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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

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K 918	Continued From page 13 B. Based on record review and interview, the provider failed to document generator battery conductivity testing monthly (no testing was being done in the past year). Findings include: 1. Record review on 2/26/25 at 10:00 a.m. revealed there was no documentation of the battery conductivity testing in the monthly maintenance logs for the generator. Interview with the maintenance director at the time of the record review confirmed that finding. He stated he was unaware of the monthly battery conductivity documentation requirement. The deficiency affected one of numerous requirements for generator maintenance. C. Based on record review and interview, the provider failed to document monthly generator load runs for 2024 and 2025 to date. Findings include: 1. Record review on 2/26/25 at 10:05 a.m. revealed there was no documentation of the monthly generator load runs (thirty minutes under load with hour meter readings and five minutes of cool-down run time) for 2024, and for January and February 2025. Interview with the maintenance director at the time of the record review confirmed that finding. He stated he was unaware of the monthly generator load run requirements.	K 918		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923	All residents have the potential to be affected. The O2 concentrators and combustible (continued)	03/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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RIVERVIEW HEALTHCARE CENTER	**611 EAST 2ND AVE** **FLANDREAU, SD 57028**

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K 923	Continued From page 14 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to protect medical gas storage as required. Oxygen concentrators and combustibles were kept with the oxygen bottles (empty and full	K 923	(continued from page 14) materials were removed from the lower level O2 cylinder storage room on 03/17/25. The ED or designee will complete audits of the O2 storage room to ensure O2 concentrators and combustible materials are not being stored in the lower level O2 cylinder storage room weekly times 1 month and monthly times 2 months.	

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	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2025**

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RIVERVIEW HEALTHCARE CENTER	**611 EAST 2ND AVE** **FLANDREAU, SD 57028**

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K 923	Continued From page 15 cylinder storage). Findings include: 1. Observation on 2/26/25 at 8:50 a.m. revealed combustible materials and three oxygen concentrators were found to be stored adjacent to and within five feet of oxygen cylinders in the lower level oxygen cylinder storage location. A wire rack held combustible plastic-wrapped spare parts. Interview with the maintenance director at the time of the observation confirmed those findings. The deficiency affected one of six smoke compartments.	K 923		

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	435086	A. BUILDING **02 - 1989 ADDITION** B. WING _____	**02/26/2025**

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RIVERVIEW HEALTHCARE CENTER	**611 EAST 2ND AVE FLANDREAU, SD 57028**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 2/26/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Riverview Healthcare Center Building 2 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 K222, K271, K353, K712, and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 271 SS=C	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the exit discharge for one of six EXIT locations (dining room south EXIT). Findings include: 1. Observation on 2/26/25 at 9:40 a.m. revealed the upper level EXIT from the dining room to the south discharged onto a concrete patio but did not extend to the public way (street). The patio was surrounded by grass. That condition would be a hindrance to egress during inclement	K 271	All residents have the potential to be affected. The ED educated the Maintenance Director on Life Safety 101, Discharge of Exits 7.1.7 on 03/23/25. Requesting a waiver to extend the compliance date to 08/26/25 to allow the facility to obtain bids to install a multi-level ADA complaint ramp to the public right-of-way or install new side walks to the public right-of-way.	03/28/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	03/23/2025

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

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	435086	A. BUILDING **02 - 1989 ADDITION** B. WING _____	**02/26/2025**

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K 271	Continued From page 1 weather. The discharge to the patio also had an approximately twelve-inch diameter scoured hole that was one-inch deep and would be a trip hazard. Interview with the administrator on 2/26/25 at 11:30 a.m. confirmed that finding. The deficiency had the potential to affect 100 percent of the smoke compartment occupants.	K 271		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow tests not done). Findings include:	K 353	All residents have the potential to be affected. The ED educated the Maintenance Supervisor on how to schedule/complete automatic sprinkler flow tests and proper record keeping of quarterly flow tests on 03/23/25. Age of sprinkler was determined on 03/20/25. Quarterly sprinkler flow test was completed on 03/21/25. The fire service company is scheduled to test sprinkler heads on 03/26/25. ED or designee will audit sprinkler logs to ensure quarterly sprinkler tests are completed timely. Audits will be completed monthly X3 months. The ED or designee will bring the results of these audits to the monthly QAPI meeting for review and recommendation to continue or discontinue audits. (continued)	03/28/25

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K 353	Continued From page 2 1. Record review on 2/26/25 at 10:10 a.m. revealed no documentation that indicated the required quarterly flow tests had been performed in 2023, 2024, and 2025. Annual sprinkler inspections were done on 6/1/23 and 6/6/24. A 5-year internal inspection was performed on 6/16/21. Interview with the maintenance director at the time of the record review confirmed those conditions. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic sprinkler system.	K 353	(continued from page 2) Requested a waiver to extend the compliance date to 08/26/25 to have our fire service professionals identify the sprinkler heads that are over 50 years of age and allow for lab testing and receive results. If one sprinkler in the test sample fails, all sprinkler heads of that type will be replaced.	
K 712 SS=F	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. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to ensure staff were familiar with the	K 712	All residents have the potential to be affected. The ED or designee will in-service all staff on fire drill procedures. The ED or designee will complete audits to ensure fire drill procedures are performed monthly time 3 months. The ED or designee will bring the results of these audit to the monthly QAPI meeting for review and make recommendations to continue or discontinue audits.	03/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 712	Continued From page 3 provider's fire drill procedures (closing corridor doors and checking the door for the fire location). Findings include: 1. Observation of the fire drill conducted on 2/26/25 at 10:30 a.m. revealed the staff member responding to the simulated fire in resident room 109 removed the resident from the room but did not shut the corridor door. That staff member was unsure of the next step to perform and asked the maintenance director for instructions. The staff member could not activate the manual pull device at the nurses' station due to its stiffness. The maintenance director had to activate the fire alarm with the manual pull station. There was no announcement of the simulated fire until three minutes into the fire drill. It was announced while the alarm buzzer was sounding and was very difficult to hear. The staff member first responding to the simulated fire location with a fire extinguisher did not check the door or the door handle of the room for heat prior to entering the room. Interview with the maintenance director at the time of the observations confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918	All residents have the potential to be affected. Replaced terminal covers on 03/17/2025. Completed battery conductivity test on 03/22/25. Completed load test on 03/22/25. The results of each test were annotated on logs. (continued)	03/28/25

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	435086	A. BUILDING **02 - 1989 ADDITION** B. WING _____	**02/26/2025**

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K 918	Continued From page 4 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: A. Based on observation and interview, the provider failed to install generator battery terminal covers as required (battery installed in 2024). Findings include: 1. Observation on 2/26/25 at 9:25 a.m. revealed the generator battery did not have terminal covers. Interview with the maintenance director at the time of the observation confirmed that finding.	K 918	(Continued from page 4) ED or designee will complete audits of conductivity test and load test weekly times 1 month and monthly times 2 months. The ED or designee will bring the results of these audit to the monthly QAPI meeting for review and make recommendations to continue or discontinue audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING **02 - 1989 ADDITION** B. WING _____	**02/26/2025**

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K 918	Continued From page 5 He stated the battery was installed in 2024. The deficiency affected one of numerous requirements for generator maintenance. B. Based on record review and interview, the provider failed to document generator battery conductivity testing monthly (no testing was being done in the past year). Findings include: 1. Record review on 2/26/25 at 10:00 a.m. revealed there was no documentation of the battery conductivity testing in the monthly maintenance logs for the generator. Interview with the maintenance director at the time of the record review confirmed that finding. He stated he was unaware of the monthly battery conductivity documentation requirement. The deficiency affected one of numerous requirements for generator maintenance. C. Based on record review and interview, the provider failed to document monthly generator load runs for 2024 and 2025 to date. Findings include: 1. Record review on 2/26/25 at 10:05 a.m. revealed there was no documentation of the monthly generator load runs (thirty minutes under load with hour meter readings and five minutes of cool-down run time) for 2024, and for January and February 2025. Interview with the maintenance director at the time of the record review confirmed that finding. He stated he was unaware of the monthly generator load run requirements.	K 918		

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 _____	02/27/2025

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/25/25 through 2/27/25. Riverview Healthcare Center was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/25/25 through 2/27/25. Riverview Healthcare Center was found not in compliance with the following requirements: S130, S169, S206, S290, S296, and S301.	S 000		
S 130	44:73:02:07 Food Service Food service must be provided by a facility or food service establishment licensed in accordance with SDCL chapter 34-18 and inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§ 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive. A facility of seventeen beds or more shall have a mechanical dishwasher. The facility shall have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation and interview, the provider failed to install an air break for the vegetable preparation sink in the kitchen.	S 130	These deficiencies have the potential to affect all residents. The maintenance director installed an air break in the drain line for the vegetable preparation sink in the kitchen to prevent back flow or back siphonage on 03/17/2025. The maintenance director replaced the shatterproof lamps and covers on the two overhead fluorescent lamps in the serving kitchen on the second floor on 02/27/2025. The ED or designee will audit weekly times one month and monthly times two months that all piping directly linked to the (cont. on next page)	03/28/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	03/23/2025

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 _____	02/27/2025

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S 130	Continued From page 1 Findings include: 1. Observation on 2/26/25 at 9:45 a.m. revealed the vegetable preparation sink in the kitchen was directly connected to the sewer system with pvc drain piping. The drain line was required to have an air break in the drain line from the sink. Interview with the maintenance director at that same time confirmed that finding. Reference: ARSD 44:02:07:67. Backflow prevention. The prevention of backflow or back siphonage must be accomplished in the following manner: (3) A direct connection may not exist between the sewage system and drain originating from equipment in which food, portable equipment, or utensils are placed. B. Based on observation and interview, the provider failed to install protective shielding or shatterproof lamps for one of two lights in the second floor serving kitchen. Findings include: 1. Observation on 2/26/25 at 9:00 a.m. revealed the serving kitchen on the second floor had two overhead fluorescent lamp fixtures. One of the fixtures did not have a cover or shield on it and did not have shatterproof lamps. Interview with the maintenance director at that same time confirmed that finding. Reference: ARSD 44:02:07:78. Lighting. Lighting must meet the following specifications for intensity and protective shielding: (2) Lighting must have protective shielding as follows: (a) Light bulbs must be shielded or coated or must be otherwise shatter-resistant in areas where there is exposed food, clean equipment,	S 130	cont from page 1. sewer system have an air break in the drain line and all overhead fluorescent lamps have shatterproof lamps and have a cover or shield in place. The ED or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	

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 _____	02/27/2025

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S 130	Continued From page 2 utensils, linens, or unwrapped single-service and single-use articles.	S 130		
S 169	44:73:02:18(5-7) Occupant Protection The facility shall: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically-activated audible alarm on all unattended exit doors. Any other exterior doors must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence when the door is closed; (7) Prohibit the use of a portable space heater, portable halogen lamp, household-type electric blanket, or household-type heating pad in the facility; This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation and interview, the provider failed to install a door alarm in one location (dining room south EXIT door). Findings include: 1. Observation on 2/26/25 at 9:10 a.m. revealed the newer dining room addition's south exterior EXIT door was not equipped with a door alarm. Interview with the administrator at that same time confirmed that finding. B. Based on observation, testing, and interview, the provider failed to maintain a door alarm in one location (lower level west EXIT door). Findings	S 169	All residents have the potential to be affected. The maintenance director replaced the exit monitoring alarm on the lower level west exterior EXIT door with an alarm that requires staff to respond to the door location on 03/20/25. The maintenance director installed a new exit monitoring alarm on the south exterior EXIT door on 03/20/25. ED or designee will audit all exit doors with door alarms to ensure alarms function properly weekly times 1 month and monthly times 2 months. The ED or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendations to continue or discontinue the audits.	03/28/25

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 _____	02/27/2025

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RIVERVIEW HEALTHCARE CENTER	611 E 2ND AVE FLANDREAU, SD 57028

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S 169	Continued From page 3 include: 1. Observation on 2/26/25 at 9:20 a.m. revealed the lower level west exterior EXIT door was equipped with a magnetic lock. Testing of the magnetically-locked door revealed it sounded an alarm as required but the alarm shut off when the door closed. The alarm must remain activated until staff respond to the door location. Interview with the maintenance director at that same time confirmed that finding.	S 169		
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	S 206	All residents have the potential to be affected. ED or designee will educate all staff on Advance Directives by 03/23/25. ED or designee will audit that all staff have received education on Advance Directives weekly times 1 month and monthly times 2 months. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	03/28/25

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S 206	Continued From page 4 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 education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee training records review, interview, and policy review, the provider failed to ensure mandatory orientation and annual training was provided on advanced directives for three of six sampled employees (registered nurse E, and certified nursing assistants J and K). Findings include: 1. Review of registered nurse (RN) E's employee file revealed: *She was hired on 11/25/24. *She had not received the required orientation training on advanced directives. 2. Review of certified nursing assistant (CNA) J's employee file revealed: *She was hired on 10/4/04. *She had not received the required annual training on advanced directives. 3. Review of CNA K's employee file revealed: *She was hired on 12/2/24. *She had not received the required orientation training on advanced directives. 4. Interview on 2/26/25 at 2:50 p.m. with director of nursing A and RN consultant C revealed: *They were aware that the topic of advanced directives was added as a required training topic in November 2024.	S 206		

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	10620	A. BUILDING: _____ B. WING _____	02/27/2025

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S 206	Continued From page 5 *RN consultant C said that she was assigning that topic as an online training requirement to all employees that day. *The orientation checklist was not updated. 5. Review of the provider's December 2017 General Orientation Checklist revealed that training on advanced directives had not been included.	S 206		
S 290	44:73:07:05 Food Supply The facility shall maintain an on-site supply of perishable and nonperishable foods to meet planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of the facility's emergency preparedness plan. A facility may use military meals ready to eat and dried milk in an emergency event according to the facility's emergency response plan. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, menu review, and policy review, the provider failed to maintain an additional supply of foods sufficient for emergency purposes. Findings include: 1. Observation and interview on 2/25/25 at 8:28 a.m. with dietary manager L in the storage room revealed: *The emergency food supply and other miscellaneous paper products were stored in the storage room. -The computer network wiring was also in that room. -The ambient temperature in the room was hot and humid.	S 290	All residents have the potential to be affected. The emergency food storage location was moved to the dry storage room in the kitchen on 03/18/2025. The emergency food order was received on 03/21/25. Inventory was completed on 03/21/25. Inventory was audited to the Emergency Three-Day Meal Plan menu 03/21/25 to meet planned menus for 3 days. ED or designee will educate FANS Manager on October 2017 Food Storage policy by 03/23/25. ED or designee will audit emergency food storage to meet planned menus for 3 days is in inventory, food storage areas are kept clean at all times, packaged food, canned foods or food items stored are kept clean and dry, food products are used within one year unless the manufacturer's expiration date (continued)	03/28/25

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S 290	Continued From page 6 *There was a layer of dust, dirt, and cobwebs on the emergency food supply. *There was a variety of foods like individual bags of popcorn, green beans, canned tuna, and canned chili. *He recently discarded most of the emergency food supply because it was expired. *He was aware that the current emergency food supply was not sufficient for their emergency meal plan. *He had an inventory sheet, but it was not updated. *The facility policy was to keep canned foods no more than one year. -Much of their current supply had been there for at least four years. *He was waiting on funding to "open up" in the food ordering guide so he could replenish the emergency food supply. 2. Observation on 2/27/25 at 8:49 a.m. in the storage room revealed the following foods were present: *One case (36 bags) of single serving "Skinny Pop" popcorn with a best by date of 6/19/23. *Six cans (48oz (ounces) each) of pulled chicken in broth with a best by date of 9/7/24. The delivery sticker indicated it was delivered on 11/15/22. *Six cans (50oz each) of chicken noodle soup with a best if used by date of 9/12/24. *Twelve cans (12oz each) of canned tuna with a delivery date of 11/15/22. There was no "best if used by" date provided by the manufacturer. *Ten cans (50oz each) of garden vegetable soup with a best by 2/24/24. It was delivered on 11/15/22. *Six cans (#10 size cans) of chili con carne with a best by date of 10/10/24. It was delivered on 11/15/22. *Six cans (#10 size cans) of beef ravioli with a	S 290	(continued from page 6) is different, the manufacturer's expiration date when available is the use by date for unopened items. The audit will be completed weekly times 1 month and monthly times 2 months. The ED or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	

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	10620	A. BUILDING: _____ B. WING _____	02/27/2025

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S 290	Continued From page 7 best by date of 1/17/24. It was delivered on 11/22/22. *Twenty-four cans (#10 size cans) of beef stew with a best by date of 9/22/24. It was delivered on 1/15/22. *Six cans (#10 size cans) of sweet peas that was delivered on 1/15/22. There was no "best if used by" date provided by the manufacturer. *Fifty individual packages of Carnation instant breakfast powdered drink mix with a best by date of 10/17/23. It was delivered on 11/15/22. *Twenty-four cartons (46 fluid ounces each) of apple juice. Twelve of the cartons had a "use by 1/7/24" date, and the other twelve cartons had a "use by 1/30/24" date. All twenty-four cartons were delivered on 5/30/23. 3. Review of the provider's October 2017 Food Storage policy revealed: *"Policy Statement: Food storage areas are maintained in a clean, safe, and sanitary environment." *"Procedure: -1. Food storage areas are kept clean at all times. -2. ...Packaged food, canned foods, or food items stored are kept clean and dry. - ...6. Food products are used within one year unless the manufacturer's expiration date is different. - ...11. The manufacturer's expiration date, when available, is the use by date for unopened items. 4. Review of the provider's July 2017 Emergency Meal Plan revealed: *"Policy Statement: The Dietary Services Department stocks emergency supplies to food residents and staff for a minimum of three days." 5. Review of the provider's July 2017 Emergency Three-Day Meal Plan menu revealed:	S 290		

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	10620	A. BUILDING: _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 290	Continued From page 8 *Day 1 breakfast consisted of 1/2 cup of fruit juice, 1/2 cup of canned fruit, 3/4 cup of dry cereal, 1 breakfast bar, 1 cup of Carnation instant breakfast drink, and 1 cup of milk. -The emergency food supply did not contain canned fruit. There was dry cereal and breakfast bars in the main dry storage area. *Day 1 lunch consisted of 6oz ravioli, 1/2 cup green beans, 1 slice bread, 1/2 cup pudding, 1/2 cup canned fruit, and 1 cup drink mix. -The emergency food supply did not contain canned fruit, pudding, or the drink mix (other than the Carnation instant breakfast drink mix and apple juice). There was bread in the main dry storage area. *Day 1 supper consisted of 6oz vegetable soup, a chicken salad sandwich, 1/2 cup pea salad, crackers, 1 cookie, and 1 cup milk. -The emergency food supply did not contain the other ingredients to make chicken salad and pea salad. There was bread, crackers, cookies, and milk in other storage areas. *Day 2 breakfast consisted of 1/2 cup fruit juice, 1/2 cup canned fruit, 3/4 cup dry cereal, 1 slice of bread with 1oz of peanut butter and a jelly packet, and 1 cup of milk. -The emergency food supply did not contain canned fruit, peanut butter, and jelly. *Day 2 lunch consisted of 1 cup beef stew, 1/2 cup "3 bean salad," crackers, 1/2 cup pudding, 1 cookie, and 1 cup drink mix. -The emergency food supply did not contain pudding, the drink mix, or the ingredients for a "3 bean salad." *Day 2 supper consisted of 6oz Minestrone soup, a tuna salad sandwich, crackers, 1/2 canned fruit, and 1 cup milk. -The emergency food supply did not contain Minestrone soup, canned fruit, or the other ingredients needed for tuna salad.	S 290		

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	10620	A. BUILDING: _____ B. WING _____	02/27/2025

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S 290	Continued From page 9 *Day 3 breakfast consisted of 1/2 cup fruit juice, 1/2 cup canned fruit, 3/4 cup dry cereal, 1 breakfast bar, 1 cup of Carnation instant breakfast drink, and 1 cup of milk. -The emergency food supply did not contain canned fruit. There was dry cereal and breakfast bars in the main dry storage area. *Day 3 lunch consisted of 3/4 cup chili, 1/2 cup canned carrots, crackers, 1/2 cup canned fruit, 1/2 cup pudding, and 1 cup drink mix. -The emergency food supply did not contain carrots, fruit, pudding, or the drink mix. *Day 3 supper consisted of 6oz chicken noodle soup, a peanut butter and jelly sandwich, 1/2 cup vegetable juice, crackers, 1 cookie, and 1 cup of milk. -The emergency food supply did not contain peanut butter, jelly, or vegetable juice.	S 290		
S 296	44:73:07:11 Director Of Dietetic Services A facility shall have a full-time dietary manager who is responsible to the administrator and who shall direct the dietetic services. The dietary manager must: (1) Be a certified dietary manager; (2) Be a certified food service manager; (3) Have a similar national certification for food service management and safety from a national certifying body; or (4) Have an associate's or higher degree in food service management or hospitality from an accredited institution of higher learning that has a course of study in food service or restaurant management. Any dietary manager who does not must enroll, within ninety days of the dietary manager's hire	S 296	All residents have the potential to be affected. A Certified Dietary Manager was hired on 03/19/25. The Certified Dietary Manager is ServSafe certified. One cook enrolled in ServSafe Food Manager certification on 03/19/25. An additonal cook completed ServSafe Food Manager certification 03/20/25. The ED or designee will audit ServSafe Certifications for dietary department weekly times 1 month and monthly times 2 months.The ED or designee will bring these results to the monthly QAPI meeting for further review and recommendation to continue or discontinue audits.	03/28/25

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S 296	Continued From page 10 date, in programming necessary to achieve one of the qualifications, and achieve the qualifications within eighteen months of hire. The dietary manager and at least one cook shall possess a current certificate from a ServSafe Manager Food Protection Program offered by various retailers, the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition and Foodservice Professionals, or an equivalent training program as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility must schedule dietitian consultations onsite at least monthly. The dietitian shall approve each menu, assess the nutritional status of each resident with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. The facility shall have sufficient personnel to meet the dietetic needs of the residents and provide dietetic services for a minimum of twelve hours each day. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure that the dietary manager and at least one cook was ServSafe certified. Findings include: 1. On 2/26/25, ServSafe certificates for the dietary manager and at least one cook were requested. On 2/27/25, the current ServSafe	S 296		

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 _____	02/27/2025

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S 296	Continued From page 11 certificate for dietary manager L was provided. 2. Interview on 2/27/25 at 9:23 a.m. with food and nutrition services (FANS) cook Q revealed that dietary manager L was no longer employed at that facility as of 2/26/25. 3. Interview on 2/27/25 at 9:56 a.m. with executive director I revealed: *He confirmed that the only dietary department staff who was ServSafe certified was dietary manager L. -He confirmed that dietary manager L terminated his employment on 2/26/25. *No other employee in the dietary department had earned their ServSafe certificate.	S 296		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by:	S 301	All residents have the potential to be affected. The VP of Food & Nutritional Services educated FANS Manager on FANS Employee Orientation, Education, and Training policy on 03/19/2025. ED or designee will educate all FANS personnel on the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. (continued)	03/28/25

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	10620	A. BUILDING: _____ B. WING _____	02/27/2025

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S 301	Continued From page 12 Based on dietary employee training review, interview, orientation materials review, and policy review, the provider failed to ensure: *Annual training had been completed on the required topics for two of five dietary employees reviewed (M and Q). *All the required dietary training topics had been provided for three of five sampled dietary employees (N, O, and P). Findings include: 1. Review of food and nutrition services (FANS) aide M's employee training file revealed: *He was hired on 9/27/22. *There was no record that he had completed training on the required annual topics for 2024. 2. Review of FANS cook Q's employee training file revealed: *She was hired on 7/17/23. *All required annual training topics were completed on 3/8/24 except for the topic of "Foodborne Illnesses." There was no record indicating she had been retrained on foodborne illnesses in 2024. 3. Review of FANS aide N's employee training file revealed: *She was hired on 1/10/24. *All required orientation training topics were completed on 3/10/24 except for the topic of "Foodborne Illnesses." There was no record indicating she had been trained on foodborne illnesses. 4. Review of FANS cook O's employee training file revealed: *They were hired on 1/18/24. *All required orientation training topics were completed on 1/18/24 and 1/19/24, except for the	S 301	(cont from page 12) ED or designee will conduct auditing and monitoring of the areas identified above weekly times 1 month and monthly times 2 months. The ED or designee will take the results of these audits to the monthly QAPI committee for review and recommendation to continue or discontinue the audits.	

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	10620	A. BUILDING: _____ B. WING _____	02/27/2025

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S 301	Continued From page 13 topic of "Foodborne Illnesses." There was no record indicating they were trained on foodborne illnesses. 5. Review of FANS aide P's employee training file revealed: *She was hired on 6/5/24. *All required orientation training topics were completed on 6/7/24 and 6/8/24, except for the topic of "Foodborne Illnesses." There was no record indicating she was trained on foodborne illnesses. 6. Interview on 2/26/25 at 2:50 p.m. with registered nurse consultant C revealed: *She could not indicate which training topic contained education on foodborne illnesses. *She indicated the dietary manager had said that he did not know the education topics were required annually. 7. Review of the provider's November 2016 FANS Employee Orientation, Education, and Training policy revealed: *"Policy Statement: The FANS Manager or designee trains new FANS employees on FANS Department functions." *"Procedure: -1. The FANS Manager or designee completes the 'Dietary Employee Orientation Checklist' for each dietary employee. -2. Regularly scheduled education is provided to support ongoing competence in practice/performance. -3. The Center utilizes company policies and procedures and inservices. Education material may be further supplemented with utilization of industry accepted standard of practice resources. -4. Annual employee performance review is completed every 12 months. Annual	S 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 301	Continued From page 14 competencies are completed as needed to address areas of improvement identified through individual performance evaluation." 8. Review of the provider's January 2015 FANS Employee Orientation Checklist revealed that the topic of foodborne illnesses was not included.	S 301		