STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/25/25 through 3/27/25. White River Health Care Center was found in compliance. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/25/25 through 3/27/25. The area surveyed was the potential for resident neglect related to staff insubordination. White River Health Care Center was found in compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi L Hodges	Administrator	4/11/25

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING _____ B. WING _____	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 3/25/25. White River Health Care 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 deficiencies identified at E004 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	E004 Develop EP Plan, Review and Update Annually All residents has the potential to be affected, however, they were not affected. The memorandum of understanding was updated for emergency evacuation on 03/25/25. Emergency Water supply updated on 04/11/25 Rosebud Sioux Tribe Water Resource and Robins Water Conditioning Inc in Fort Pierre SD. Emergency MOA will be reviewed yearly by both parties in MOA and reviewed with QA quarterly for the next year or until in compliance.	04/11/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle L Hodges | TITLE: Administrator | (X6) DATE: 4/11/25

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING _____ B. WING _____	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 agreements (emergency, evacuation transfer) annually. Findings include: Record review on 3/25/25 at 1:15 p.m. revealed no documentation that the provider's current emergency preparedness plan memorandums of understanding/agreements were updated annually. For example, there were no current updated copies of signed agreements for water supply and evacuation.	E 004		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING _____ B. WING _____	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004	Continued From page 2 Interview with the administrator on 3/25/25 at 1:30 p.m. confirmed those findings.	E 004		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 3/25/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. White River Health Care 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 deficiencies identified at K345 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to maintain one of one fire alarm system as required. Findings include: 1. Record review on 3/25/25 at 10:45 a.m. revealed the annual fire alarm inspection report dated 7/10/24 did not list sensitivities for the ionization-type smoke detectors. Ref: 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11	K 345	K345 Fire Alarm System-Testing and Maintenance All residents had the potential to be affected however, they were not affected. The administrator contacted ABC automatic building controls, Inc previous vendor for all annual and quarterly fire alarm inspections report for a sensitivity for ionization type smoke detectors for services. ABC scheduled for April 16th, 2025, inspection for sensitivity on smoke detectors. The administrator requested a waiver until 04/18/25. The facility confirms from this day forward using ABC for all the quarterly inspections and annual reports from this day 04/11/25.	04/11/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maude L Hodges — TITLE: Administrator — (X6) DATE: 4/11/25

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

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K 345	Continued From page 1 2. Interview with the administrator on 3/25/25 at 1:30 p.m. confirmed those findings. The deficiency affected 100% of the occupants.	K 345		
K 712 SS=C	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 record review, observation, and interview, the provider failed to: *Conduct fire drills for a minimum of one per shift per quarter for 2024 and 2025 for all three shifts. A total of thirteen fire drills were held from April 2024 through March 2025. No fire drills were held for the third shift during that time period. *Conduct fire drills at varying times. Two drills were held at 4:00 p.m., three drills were held at 2:00 p.m. to 2:30 p.m., and four drills were held at 1:00 p.m. to 1:30 p.m. Findings include: 1. Record review on 3/25/25 at 11:30 a.m. of the provider's documentation of fire drills for April 2024 through March 2025 revealed fire drills were	K 712	K712 Fire Drills All residents had the potential to be affected, however, they were not affected. In-Service done with maintenance supervisor on 04/11/2025 on fire drills by the administrator. The Administrator and Maintenance Supervisor will monitor drills with an auditing tool enforced ensuring fire drills are done on every shift. Fire Drills will be done weekly starting on 04/05/25 on each shift for one (1) month then on each shift monthly for six months. Fire drills and documentation will be reviewed monthly with the Maintenance Director by the Administrator. This will be reviewed at QA until the committee feels in compliance.	04/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/25/2025

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K 712	Continued From page 2 conducted on: 4/4/24 at 7:30 a.m. 5/30/24 at 2:22 p.m. 6/18/24 at 11:30 a.m. 7/23/24 at 1:00 p.m. 8/3/24 at 10:00 a.m. 9/30/24 at 2:30 p.m. 10/4/24 at 9:00 a.m. 11/20/24 at 2:00 p.m. 12/14/24 at 4:00 p.m. 12/30/24 at 1:50 p.m. 1/21/25 at 4:00 p.m. 2/27/25 at 1:30 p.m. 3/25/25 at 1:00 p.m. 2. Record review on 3/25/25 at 11:40 a.m. revealed the fire drill sign-off sheets for staff did not include: *Documentation of who received the fire alarm signal at the monitoring agency. *The time it was received at the monitoring agency. Interview with the administrator during the exit interview on 3/25/25 at 1:30 pm. confirmed those findings and their operation of three shifts. The deficiency had the potential to affect 100% of the building occupants.	K 712		

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
	10710	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

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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 3/25/25 through 3/27/25. White River Health Care Center was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on 3/25/25 through 3/27/25. White River Health Care Center was found not in compliance with the following requirement: S430.	S 000		
S 430	44:73:12:27(1-3) Ventilating Systems The facility's ventilating systemsmust meeting the following requirements: (1) All occupied areas of the building must maintain a minimum humidity level of fifteen percent relative humidity provided through the building central ventilation system; (2) Beauty shops must provide a minimum of fifteen air changes per hour of exhaust ventilation when the room is in use; and (3) Toilet and bathing rooms must provide a minimum of ten air changes per hour of exhaust ventilation. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in one location (public restroom by the nurses' station). Findings include:	S 430	S430 Ventilating Systems All Residents had the potential to be affected, however they were not affected. The administrator did training on the HVAC systems with the policy emphasizing the importance of maintenance and repairs to the HVAC System to the maintenance supervisor on 04/11/2025. The maintenance supervisor will do audits on the HVAC system and inform the administrator when system needs repair and call for repairs and follow-up when needed. Maintenance Supervisor will audit weekly to ensure ventalation systems are working properly. The administrator will review audits monthly for the first six months and as needed after compliance is met. Will be reviewed at QA/QAPI monthly for six months or until substantial compliance is obtained.	04/11/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda L Hodges — TITLE: Administrator — (X6) DATE: 4/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10710	A. BUILDING: _____ B. WING _____	03/27/2025

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S 430	Continued From page 1 1. Observation and testing on 3/25/25 at 10:00 a.m. revealed the exhaust ventilation for the public restroom at the nurses' station was not functioning. Interview with the administrator at that same time confirmed that finding. She stated the exhaust fan served several different rooms. She stated a quote was being obtained from a contractor to repair the exhaust fan.	S 430		