STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435086**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/25/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/23/25 through 9/25/25. Areas surveyed included potential abuse/neglect of residents related to pain control,, physical and mental abuse, medication errors, and resident safety related to elopements. Riverview Health Care Center was found not in compliance with the following requirement(s): F600, F689, F697, and F760.	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on review of South Dakota Department of Health Facility Reported Incident (SD DOH FRI), interview, record review, and policy review, the provider failed to protect the resident's right to be free of abuse by: *One of one certified nursing assistant (CNA) T who slapped a resident’s door and told that resident that she would get her pain medication when her name came up on the nurse’s list, when one of one resident (7) requested pain medication. The resident reported that interaction caused her increased anxiety.	F0600	1. All residents have the potential to be affected. 2. Resident # 7 was discharged from the facility on 9-24-2025. 3. Both C.N.A(T) and C.N.A/CMA(U) and C.N.A (V) were terminated from the facility after their suspension. 4. All nursing and non-nursing staff were educated on Abuse and neglect and examples of abuse and neglect such as using intimidation when responding to needs, refusing to assist residents with medication administration, grabbing at and attempting to take away items from residents, communication and cares with a resident who has dementia or developmental delays or communication barriers. All staff meetings were held on 9-29-2025 and 9-30-2025. All staff who are not in attendance will be educated at their next scheduled shift.	9-30-2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lourdes Parker	Interim Administrator	10-17-2025

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F0600 SS = G	Continued from page 1 *One of one certified medication aide (CMA) U who refused refused to assist a resident with taking medication for one of one sampled resident (6) who cried and expressed feelings of emotional distress. *One of one CNA V who told a resident he would fight him, grabbed the resident’s arm, and took a breakfast bar from one of one sampled resident (5) with diet restrictions who took a breakfast bar from a snack cart. Findings include: 1. Review of the provider's 8/19/25 SD DOH FRI revealed: *On 9/19/25, resident 7 reported to social services designee (SSD) E that she used her call light to request pain medication, Certified Nursing Assistant (CNA) T answered the call light and told resident 7 “You will get your pain medication when your name comes up on the list.”, then left the resident's room. -Resident 7 put on her call light again, CNA T responded to her call light “in an unpleasant tone and manner.” and said to resident 7, “I told you you will get your medicine when the medication nurse gets to you, and slammed her fist on the door.” *Resident 7 told SSD E that the interaction with CNA T that day “made her feel distressed.” *Resident 7 told SSD E that if she were to see CNA T again, “it would cause her a great deal of anxiety.” *CNA T was suspended pending further investigation by the provider. Interview on 9/24/25 at 8:50 a.m. with resident 7 regarding the 8/19/25 incident revealed: *She recalled she had increased pain that day and put her call light on to ask for pain medication. *She did not recall receiving care from CNA T before that day. *She stated that the first time she put on the call light, CNA T was rude and said “You will get your pain medication when your name comes up on the list.” *She reported putting on her call light again a few	F0600	5. DNS or designee to audit 4 residents weekly times, four weeks then monthly time two months to question if they are safe and have no concerns with their cares and any signs or symptoms of abuse/neglect noted. DNS or designee to audit 5 samples weekly times four weeks, then monthly times two months to interview residents to ask them if their pain is being managed. 6. On 9-29-2025, designated RN completed audits on all residents who have reported pain. Audit included ensuring pain medications were on MAR, interviews with residents to see what staff can do to alleviate pain, schedule pain medications needed, non-pharmacological pain interventions on care plans an care plans updated. 7. DNS or designee will bring audits to the next monthly QAPI committee meeting for review to determine if the audits will need to be continued or can be discontinued.	

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

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F0600 SS = G	Continued from page 2 minutes later, CNA T answered the call light again, and said “I told you, you will get your medications when the nurse gets to you, and then slapped the door with her hand.” -Since then, she did not want to put on her call light and she felt increased anxiety when she would see CNA T walking by her room. Interview on 9/24/24 at 10:40 a.m. with CNA AA revealed: he worked with CNA T on the day of the above incident and did not witness that incident or CNA T exhibiting negative interactions with residents that day. Interview on 9/25/25 at 9:52 a.m. with RN G revealed resident 7 often rated her pain at a six (on a zero to ten pain scale) and stated resident 7 was "very anxious." Interview on 9/25/25 at 11:13 a.m. with director of nursing (DON) B revealed: *When CNA T was interviewed about the incident by DON B, "Her manner was very rude. Her language was not professional." *The DON reported that CNA T referred to the resident 7 as "the lady with all of the tubes." "CNA T did not deny her actions or apologize for them during the interview. *DON B reported that CNA T would no longer be employed due to her treatment of resident 7. 2. Review of the provider’s 4/29/25 submitted SD DOH FRI regarding resident 6 revealed: *Resident 6’s Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. *On 4/27/25 at 8:00 a.m.an argument had occurred between resident 6 and CNA/CMA U when the resident was administered her medications. -Resident 6 had asked for CNA/CMA U to assist her with her cup of water when taking her medications.	F0600		

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F0600 SS = G	Continued from page 3 *Medication pills and water were found lying on the floor of resident 6's room after CNA/CMA U had left the room. *Resident 6 indicated CNA/CMA U was rude and did not want to help her with small things. *The incident was reported by CNA H on 4/28/25 to the former director of nursing (CC). *The resident's emergency contact, primary care provider, and local law enforcement were notified of the incident. *The provider reviewed resident 6's care plan which showed: -"Schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar), trauma, bipolar, and acute and chronic anxiety." -Nutritional assistance needed by one staff if hands are not working properly. *Her care plan did not include that she self-administered of any medications. *Interventions included: -Offer reassurance and support as needed. -Provide safe and welcoming environment interactions. -One staff member for assistance with nutritional needs. -Interviews with 3 random residents were conducted to ensure the residents were receiving appropriate care. *Based on the provider's investigation, findings the provider verified the incident due to resident 6's statement. Interview on 9/23/25 at 12:40 p.m. with registered nurse (RN) G revealed she: *Heard something had happened between resident 6 and CNA/CMA U but was not aware of what happened. *Indicated that resident 6 did not mention to her that an incident had occurred between her and CNA/CMA U.	F0600		

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F0600 SS = G	Continued from page 4 *Did not feel resident 6 exhibited behaviors that indicated she was upset after the incident had occurred. *Thought CNA/CMA U presented as a “hot head” and did not always get along with other staff members. Interview on 9/23/25 at 12:49 p.m. with resident 6 revealed she: *Did not recall an incident where she had been upset with staff member CNA/CMA U. *Denied knowing CNA/CMA U or if she had worked at the facility. *Had received appropriate care at the facility and stated, “staff are doing the best that they can do.” *During the investigation, resident 6 stated to former DON CC “She made me feel like a dummy and that I didn’t know anything about my medications” Interview on 9/23/25 at 2:40 p.m. with CNA H revealed: *On 4/27/25 she had heard a confrontational argument between resident 6 and CNA/CMA U in the resident’s room. *When she entered the resident’s room, the resident had been crying and stated, “I don’t want her in here” and pointed at CNA/CMA U. *Resident 6 indicated to CNA H, she had asked for CNA/CMA U to remain by her side when she took her medications and CNA/CMA U refused to assist the resident with her cup of water or to remain by her side when she took her medications. Interview and record review on 9/23/25 at 4:05 p.m. with RN I revealed: *There was no active order on resident 6’s medication administration record (MAR) that indicated staff were to remain with the resident when administering medications. *Resident 6’s care plan did not include staff were to remain with the resident when medications were administered or to assist her with her cup of water.	F0600		

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F0600 SS = G	Continued from page 5 *She indicated resident 6 requested staff to remain with her and assist her when taking her medications. Record review of resident 6's electronic medical record (EMR) revealed: *Care plan, MAR, TAR (treatment assessment record), and active and discontinued physician orders did not reveal that staff must remain with the resident when her medications were administered. *Resident 6 's self-administration of medication evaluation had been completed on 4/24/25 and indicated the resident was unable to self-administer medications. On 9/24/25 at 1:05 p.m. the provider provided documentation that revealed: *CNA/CMA U had received education on abuse, reporting, and neglect of residents. -Unable to interview former administrator BB and former DON CC that were employed at the facility, at the time the incident had occurred on 4/27/25, as they no longer are employed at the facility. 3. Review of the provider's 8/28/25 submitted SD DOH FRI regarding resident 5 revealed: *His Brief Interview for Mental Status (BIMS) assessment score was 00, which indicated his cognition was severely impaired. *On 8/28/25 at 9:35 p.m. resident 5 was observed taking a breakfast bar from the snack cart. *The resident's diet was regular with pureed food and thickened liquids. *He was educated on his diet restrictions by licensed practical nurse (LPN) O, but the breakfast bar was not taken away from the resident. *LPN O witnessed CNA V approach the resident and in a joking manner, and indicated he would fight the resident for the breakfast bar. *Actions by CNA V escalated and became aggressive towards the resident.	F0600		

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F0600 SS = G	Continued from page 6 *He had approached the resident in a boxing-type movement (closed fists in the air) and circulated his body around resident 5, who was seated in a wheelchair. *CNA V grabbed the resident’s arm and took the bar from the resident’s hand. *The resident and CNA V were separated by LPN O and CNA J. *The resident was assessed by LPN O and no injuries were found at that time. *CNA V had no further contact with the residents after the incident. His shift ended that day at 10:30 p.m. *The resident’s emergency contact and primary care provider were notified. *Review of the resident’s care plan showed: -He had a diagnosis of bipolar (manic depression), behavior syndromes associated with physiological disturbances and physical factors, intellectual disabilities, adjustment disorder with depressed mood, and cerebral palsy (CP) (a disorder that affects a person’s ability to move, maintain balance, and control posture caused by abnormal brain development most often occurring before birth). -He had a communication problem related to a hearing deficit, neurological symptoms, and weak or absent voice due to CP. -The resident shook his head back and forth to indicate “No” and shrugged his shoulders to indicate “Yes.” *Interventions included: -"When communicating with the resident, allow adequate time to respond, repeat as necessary, do not rush, request clarification to ensure he understands and face him when speaking." -"Ensure and provide safe environment." *Based on the provider’s investigation, the provider verified the incident. -CNA V had violated policy and his employment at the facility was terminated on 9/5/25.	F0600		

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F0600 SS = G	Continued from page 7 Resident 5 was not interviewed because the resident was nonverbal. Interview on 9/24/25 at 9:55 a.m. with LPN O revealed she confirmed the incident as described in the facility reported incident (FRI): *Had witnessed resident 5 take a breakfast bar from the snack cart on 8/28/25 at 9:35 p.m. -Did not take the breakfast bar from the resident but provided education on his special diet. *Witnessed CNA V when he had approached the resident, in what she believed was in a joking manner. *Indicated CNA V had told the resident; he would fight him for the breakfast bar and his actions became aggressive and escalated towards resident. *Indicated CNA V had approached the resident in a boxing type movement (closed fists in the air) and had circulated his body around the resident who was seated in the wheelchair. -Witnessed CNA V grab the resident's arm and retrieved the bar from the resident's hand. *Separated CNA V and the resident with assistance from CNA J. *Assessed the resident and no injuries were found at that time. On 9/24/25 at 1:05 p.m. documentation was provided and revealed: *CNA V had received education on abuse, reporting, and neglect of residents. Interview on 9/25/25 at 8:36 a.m. with CNA J revealed: *She indicated on 8/28/25 at 9:35 p.m. resident 5 was having an "off night" and was being confrontational. *CNA V was passing out bedtime snacks to the residents. *Resident 5 took a breakfast bar from the snack cart. *CNA V grabbed the resident's arm and took the bar from	F0600		

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F0600 SS = G	Continued from page 8 the resident’s hand. *She confirmed she and LPN O separated CNA V and the resident. Interview on 9/25/25 at 1:28 p.m. with CNA H revealed she: *Referred to the resident’s Kardex (quick reference medical record system) and the resident information on the assignment sheets to know how to care for residents. *Indicated resident 5 had exhibited aggressive behaviors in the past. *Would accommodate resident 5 such as when he wants to get out of bed, to alleviate any negative behaviors. Interview on 9/24/25 at 3:05 p.m. with administrator A revealed: *She expected that staff would report to the director of nursing DON or herself, any resident abuse or neglect concerns. *A staff member reported in a suspected abuse incident would be suspended until the investigation was completed. *No documentation was provided that indicated all staff members had received abuse and neglect training after the 8/28/25 incident. *Former assistant director of nursing (ADON) DD and the former DON CC were notified of the incident directly after it had occurred. -They were not interviewed as they no longer work at the facility. Review of the provider’s 3/2025 CNA job description revealed: *”Reporting Relationships, 1. Reports to the Licensed Nurse directing and overseeing resident care on assigned unit.” Review of the provider’s 10/2022 Abuse Reporting and	F0600		

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F0600 SS = G	Continued from page 9 Response policy revealed: *"Policy Statement: The center immediately reports all suspected and or allegations of abuse, neglect, and exploitation of residents, misappropriation of resident property, mistreatment, and injuries of unknown source in accordance with state and feral law." -"Staff immediately reports all alleged or suspected violations to the supervisor and Executive Director." -"Reports of alleged violations by others such as staff, residents, visitors, other health care providers, or others do not need to be explicitly characterized as "abuse", "neglect", "mistreatment", or "exploitation" to require reporting, investigation, and further necessary steps." *"The Executive Director or designee reports alleged violations to the state survey agency and other officials in accordance with state law (such as Adult Protective Services and local law enforcement) as follows:" *"c. Serious bodily injury means an injury involves extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation." Review of the provider's 10/2022 Abuse Investigation policy revealed: *"Policy Statement: The center conducts a thorough investigation of potential, suspected and or allegations of abuse, neglect, and exploitation of residents, misappropriation of resident property, mistreatment, and injuries of unknown origin, in accordance with state and federal regulations." -"The center identifies and interviews, involved person, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations." -" The center protects the alleged victim during and after the course of the investigation."	F0600		
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F0689	1. All residents have the potential to be affected.	9-30-25

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F0689 SS = E	Continued from page 10 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, observation, interview, record review, and policy review, the provider failed to implement interventions to ensure the safety of two of two sampled residents (1 and 2) who eloped (left the facility without staff knowledge). Failure of the staff to ensure adequate supervision and interventions put those residents at risk for physical injury or serious harm. Findings include: 1. Review of the provider's 7/3/25 SD DOH FRI revealed: *On 7/3/25, registered nurse (RN) Q noticed resident 1 was missing at 8:15 p.m., and instructed facility staff members to search all rooms and the perimeter of the facility. *The sheriff was notified, and the search was extended into the community. *Resident 1 “exited the doors leading to the patio area. The door is not alarmed but is wanderguard [WanderGuard door alarming system] protected.” *Resident 1 had not signed out at the nurses' station or let staff know he was leaving. *Resident 1 “stated he wanted a pack of cigarettes and decided to walk uptown to get a pack.” *”Staff members [maintenance worker L and support services M] located the resident, at Bar X.” *”The resident was back in the facility at approximately 9:00 p.m.,” and was assessed for injury. *Resident 1 was educated “that he is to sign out and sign back in at the nurses station each time he leaves	F0689	2. DNS and IDT reviewed elopement binder and updated resident 1 and 2’s elopement evaluation and the binder to best fit the definition of elopement risk and care plan updated along with the binder. All residents who were deemed elopement risks were reviewed and elopement evaluations and care plans were updated by 9-30-2025. 3. United Technologies, Red White, came out to the facility by 9-8-25 to assess proper functioning of wander guard and door alarms. 4. All non- nursing and nursing staff were educated at the All staff meetings, on the Elopement and Wandering policy, held on 9-29-2025 and 9-30-2025. All staff who are not in attendance will complete on their next scheduled shift. 5. DNS or designee to audit 5 residents’ charts to ensure elopement evaluations are completed and care plan updated and elopement binder is updated if applicable, weekly times four weeks, then monthly times two months. 6. DNS or designee will bring audits to the next QAPI committee meeting for review and recommendations, to continue or discontinue audits.	9-30-25

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F0689 SS = E	Continued from page 11 the facility,” and to “let nursing staff know when he is going outside and when he returns.” *”Exit leading to patio had a new lock with a keypad installed on 07/07/25.” Review of resident 1's electronic medical record (EMR) revealed: *He was admitted to the facility on 5/28/25. *His diagnoses included a fracture of the left femur (upper leg bone), alcohol abuse, and tobacco use. *His 6/3/25 Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated his cognition was moderately impaired. *His 6/1/25 Elopement Risk Evaluation indicated: -The question “The resident is comatose, dependent on ADL and cannot move without assistance, and or stuporous?” Was answered “Yes.” -He was not an elopement risk because he “Requires assistance from staff for mobility.” *His 5/30/25 care plan (personalized plan that addresses a resident’s care needs, goals, and interventions) functional abilities focus area indicated that he: -Required “Partial/Moderate assist of one [staff member] in [his] wheelchair in [the] facility.” -“Does not ambulate independently in [the] facility; only with therapy at this time.” -Used a wheelchair and a walker. -Transferred with “Partial/moderates [moderate] assist [with a] gait belt [a waist strap gripped as support for safe mobility and transfers] and one staff [member].” -Was “Alert and oriented to time, place and situation.” Observation and interview on 9/23/25 at 2:38 p.m. with resident 1 revealed: *He recalled that “over a month ago” when he was	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

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F0689 SS = E	Continued from page 12 sitting outside on the patio, he decided to “go get a pack of cigarettes.” *He had been sitting on the patio in his wheelchair with another resident. There was no staff on the patio with them. He left his wheelchair and walked, without a walker, up the hill and then downtown to a small bar. He did not tell anyone that he was leaving. *He thought he had been gone from the facility for a little over an hour. *A staff member from the facility came to the bar and gave him a ride back to the facility that evening. *An alarm was placed on the patio door, and staff had to enter a code on the door alarm keypad and sign him out in a book to allow him to go outside to sit on the patio. -That alarm was not on the patio door when he had left the facility on 7/3/25, and he was able to go out on the patio whenever he wanted, because the door was not locked, alarmed, or monitored by staff at that time. *He did not wear a WanderGuard device on his person or have one on his wheelchair. He could not recall if he had one since being admitted to the facility, but knew that his roommate wore one, because it set off the door alarm when he got too close. Interview and review of the resident sign-out book on 9/23/25 at 3:37 p.m. with RN Q revealed: *RN Q worked on 7/3/25 when resident 1 left the facility without notifying the staff. *RNQ found his wheelchair on the patio, realized that he was missing, and had staff members begin looking for him. *Support services (SS) M called the facility, and maintenance director (MD) F brought resident 1 back to the facility. *RN Q did not recall what time those above actions had occurred on 7/3/25. *There was a sign-out book at the nurses' station where residents had to be signed out by a staff member to sit on the patio. *Resident 1 had not signed out in that book on 7/3/25.	F0689		

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F0689 SS = E	Continued from page 13 *Resident 1 was last documented as signed out by certified nursing assistant (CNA) W on 9/8/25 and had not been signed back in. Interview on 9/23/25 at 4:04 p.m. with SS M regarding the events of 7/3/25 revealed: *On 7/3/25, she saw resident 1 enter the bar looking for cigarettes. *She called and notified the facility where resident 1 was, and MD F went to the bar and gave resident 1 a ride back to the facility. *SS M thought that the bar was located at least a half-mile from the facility. Observation and interview on 9/24/25 at 9:06 a.m. about the second-floor patio exit doors with MD F revealed: *He confirmed that he gave resident 1 a ride back to the facility on 7/3/25 when he had left the facility without staff knowledge. *A new door alarm was installed on that second-floor patio door on 7/7/25. *Before 7/7/25, that door had not been alarmed or monitored by a staff member, and residents were allowed to go out on the patio if they let a staff member know. *The second-floor patio doors had a system that would alarm if a resident who wore a WanderGuard device tried to exit those doors. *Resident 1 did not wear a WanderGuard device, so those patio doors would not alarm when resident 1 exited through those doors. 2. Review of the provider's 9/2/25 SD DOH FRI revealed: *"It was reported on 9/2/25 that resident [resident 2] was sitting outside [the] facility." *The report indicated that the Time of the Event was 10:30 a.m. and that resident 2 had a WanderGuard "in place" that "did not activate." *Resident 2 stated, "he wanted to go outside and talk to a guy." "It was reported that he [resident 2] was	F0689		

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F0689 SS = E	Continued from page 14 talking to another male resident who goes outside." *"[A] New wander guard [was] placed on [the] resident." *Maintenance staff assessed the door and alarm system, and the door alarm company was to come out to the facility on 9/4/25. *The WanderGuard representative "stated that the wanderguard bracelet needs to be placed on the [resident's] left ankle in order to alarm when he [resident 2] is going through the first-floor door." *It was noted that resident 2's WanderGuard was on his right ankle. The WanderGuard was then placed on resident 2's left ankle. Review of resident 2's electronic medical record (EMR) revealed: *He was admitted to the facility on 10/11/24. *His diagnoses included Epilepsy (a chronic neurological condition characterized by seizures), mild cognitive impairment, and Alpers Disease (a rare progressive neurodegenerative disorder). *His 1/14/25 BIMS assessment score was 12, which indicated his cognition was moderately impaired. *Elopement assessments were completed on 3/26/25, 5/6/25, and 9/3/25. *His 5/6/25 Elopement Risk Evaluation indicated: -The question "The resident is comatose, dependent on ADL and cannot move without assistance, and or stuporous?" Was answered "Yes." -He was not an elopement risk because he "Requires assistance from staff for mobility." *A 6/8/25 physician's order indicated "wander guard check every shift." *A 6/8/25 progress note indicated, "Resident getting stronger. He wanders. E-care notified with [an] order for [a] wander guard [WanderGuard]." -There was no documentation that an elopement risk assessment had been completed since 5/6/25. *His 8/26/25 BIMS assessment score was 15, which	F0689		

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F0689 SS = E	Continued from page 15 indicated he was cognitively intact. Review of resident 2’s care plan revealed: *A WanderGuard had been in place from 11/29/24 through 3/26/25. -Documentation of his elopement risk was marked “RESOLVED” on 3/26/25. *His updated 8/5/25 care plan's interventions indicated: -“Please remind me to call for assistance when I need to stand, transfer, or complete tasks that involve balance requirements.” *A 9/9/25 intervention “Wanderguard to be placed on left leg only.” *A 9/12/25 behaviors focus area included “Exit seeking/elopement.” Observation and interview on 9/23/25 at 2:50 p.m. with resident 2 revealed: *He moved about the facility independently in his wheelchair. *He stated that on 9/2/25, he had pushed on the front door, and it opened, so he went outside. *He had wanted to go to McDonald's, but was talking to another resident when the staff brought him back inside. *He wore a WanderGuard device on his left ankle and knew that would make the door alarm go off. -He was unsure if the door alarm had gone off that day. *He stated he needed permission to go outside, but did not tell anyone that he was going outside. Observation and interview on 9/24/25 at 11:02 a.m. with resident 3 regarding the process to exit the facility and sit outside revealed: *Resident 3 had a power wheelchair and was allowed to leave the facility after signing out. A staff member had to enter a code at the main door and let him out	F0689		

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F0689 SS = E	Continued from page 16 through the front entrance doors. *He recalled that a couple of months ago, a new door alarm had been added to the patio door, and staff had to sign him out and enter a code before he was allowed to go on the patio. Before that, he could go out on the patio whenever he wanted. *He was outside in front of the facility, a couple of weeks ago, when resident 2 had exited the facility through the front door without a staff member's assistance. *Resident 3 was not sure how resident 2 had opened the door, or if someone had let him out. Resident 3 knew that resident 2 had a WanderGuard, but stated that the WanderGuard door alarm had not sounded that day (9/2/25). Observation and interview on 9/24/25 at 1:10 p.m. with MD F of the first-floor main entrance doors revealed: *On 9/2/25, MD F had seen resident 2 sitting outside the main entrance doors from the second-floor window and knew he should not be out front without a staff member. *MD F alerted certified nursing assistant (CNA) H, who assisted resident 2 back inside the facility. -MD F did not know how long resident 2 had been outside without the staff's knowledge. *The WanderGuard door alarm had not sounded. He was unsure if the main door alarm had sounded and had been turned off. *He thought that resident 2 had followed resident 3 out the main entrance doors after staff had entered the code and the electric door openers had been pressed, allowing resident 3 to exit, because resident 2 was able to move in his wheelchair "pretty quickly." -MD F turned off the electric door openers so that staff now have to hold the door open when a resident is allowed to go outside from the main entrance doors. *MD F had tested resident 2's WanderGuard on 9/2/25 after resident 2 was found outside and stated that the WanderGuard appeared to be working; however, it was replaced that day (9/2/25). *The door alarm vendor came to the facility on 9/4/25	F0689		

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F0689 SS = E	Continued from page 17 and tested the door and WanderGuard alarm systems, and they were in “working order.” *MD F said the door alarm vendor concluded that the reason the door alarm had not activated on 9/2/25 was because the resident’s WanderGuard bracket was placed too low and too far to the right of the door for the alarm to be activated. The vendor recommended that resident 2 wear the WanderGuard bracelet on his left ankle. Interview on 9/24/25 at 1:28 p.m. with CNA H revealed: *On 9/2/25, after breakfast, she had been alerted to resident 2 sitting outside the main door and had seen him from the upstairs window about 10 to 15 feet from the main door as she went down the steps to get him. *The door alarms were not sounding at that time, and resident 2’s WanderGuard did not activate the alarms when she brought him back inside the facility that day. *There was a wheelchair transportation van located outside the front door, and she thought that resident 2 might have accidentally been let outside by the van driver. 3. Interview on 9/24/25 at 1:55 p.m. with administrator A and director of nursing (DON) B revealed: *Neither administrator A nor DON B had been working for the facility when resident 1 had left the facility on 7/3/25. -The administrator, DON, and assistant DON who had worked at the facility on 7/3/25 were not available for interview. *The patio doors were alarmed now; however, neither of them knew the status of the alarm system on the patio doors on 7/3/25, nor did they have any additional knowledge of the events that occurred when resident 2 was found downtown after leaving the facility without staff knowledge. *Administrator A had not been working for the facility when resident 2 was found outside in front of the building without staff knowledge on 9/2/25. *DON B stated that resident 2 had been found outside in front of the building; she was unsure how he had gotten there. DON B explained that it had been determined that	F0689		

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F0689 SS = E	Continued from page 18 resident 2's WanderGuard needed to be on his left ankle when worn on his lower legs to activate the alarm. *They expected that the staff members would have signed residents out in the binder at the nurses' station and entered the door code to allow residents to access the patio, and that residents would be signed back in, in that same binder, to track who was out on the patio. -Most residents did not require a staff member to remain on the patio with them unless it had been determined that they were unsafe to be on the patio unsupervised, and they had a WanderGuard. A staff member would supervise a resident with a WanderGuard when they were out on the patio. *They expected that residents assessed to be safe to leave the facility independently would sign out in the sign-out book and be allowed to exit the facility through the main entrance doors. All other residents would be signed out and then supervised by a family member or staff member when leaving the facility through the main entrance doors. Review of the provider's updated February 2025 Elopement/Wandering policy revealed: *"Elopement: The resident/patient exits the Center without staff knowledge OR the resident/patient enters an unsafe area without staff knowledge or presence." *"A resident exits the front door without staff knowledge or presence. This is elopement." *A resident with substance use disorder, leaves the premises without signing out or doesn't let staff know they are leaving. This is an SUD [substance use disorder] elopement." *"Based on the result of the Elopement/Exit seeking Evaluation, care plan interventions to manage wandering and/or exit seeking behaviors are initiated/implemented."	F0689		
F0697 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	F0697	1. All residents have the potential to be affected. 2. Unable to correct deficiency with resident 7 as she discharged from the facility on 9-24-2025.	9-30-25

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F0697 SS = G	Continued from page 19 comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to provide effective pain management to one of one resident (7) who transferred to the emergency department with complaints of increased pain. Findings include: 1. Observation and interview on 9/24/25 at 8:50 a.m. with resident 7 revealed: * She had resided at the facility for about a month. *She had increased pain over the past several days. *She reported that her pain was not being adequately controlled and was getting worse. *Her left lower abdomen was visibly swollen. *She reported she was not able to turn to her side anymore due to the discomfort. *She stated, “the nurses have looked at it”, but she did not feel anything was being done. *She stated, “I’d like to see my specialist.” 2. Review of resident 7’s electronic medical record (EMR) revealed: *She had medical diagnoses that included secondary malignant neoplasm (cancer) of other digestive organs, acute kidney failure (kidney's inability to filter blood properly), and anxiety disorder (a disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). *She was sent to the emergency department to be evaluated for increased abdominal pain on 9/14/25. -While in the emergency department, she received Fentanyl a controlled (medications at risk for abuse and addiction) pain medication, and Lorazepam, a controlled medication for anxiety. *She was discharged from the emergency department and	F0697	3. Facility audit was completed, and residents who had reported pain, had pain interviews completed, by the RN education instructor ensure that pain medication regimen was present and effective, and care plans updated, on 9-29-2025 4. All staff educated on the Pain management policy and follow up, at All Staff meetings held on 9-29-25 and 9-30-25. All staff not in attendance will be educated on their next scheduled shift. 5. DNS or designee to audit 5 residents weekly times four weeks, then monthly times two months, to ensure pain is being managed with current treatments. 6. Residents who need further pain management are being referred to a pain management MD and will be followed by the specialist. 7. DNS or designee will complete random audits weekly times four weeks, then monthly times two months to check MAR to ensure pain levels are being monitored and pain medication is being given if indicated or requested. 8. DNS or designee will bring audits to the next monthly QAPI committee meeting for review and recommendations to continue or discontinue audits.	9-30-25

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F0697 SS = G	Continued from page 20 returned to the facility on 9/14/25 with orders to have a follow-up appointment with her primary care physician in two to four days. *No documentation indicated a follow-up appointment with her primary care provider was made. No follow-up care from the emergency department visit was obtained. *On 9/15/25 and 9/16/25, she received three doses of PRN oxycodone 2.5 mg. *A progress note entered on 9/16/25 at 11:12 p.m. by licensed practical nurse (LPN) Y stated, “Resident [resident 7] c/o [complains of] her abdomen getting bigger with fluid. LLQ [left lower quadrant of her abdomen] does appear bigger than [the] right and [resident 7] stated she is having more pain and pressure.” *On 9/17/25, 9/18/25, and 9/19/25, she received two doses of PRN oxycodone 2.5 mg. *A progress note entered on 9/18/25 at 3:58 p.m. by RN G stated, “PRN [as needed] lorazepam was administered twice today for c/o anxiety. Resident [resident 7] noted to be restless at times. She was reminded to write down when she takes medication as she is forgetful and overfocuses on PRN acetaminophen [Tylenol] and lorazepam.” “PRN acetaminophen [was] administered today x2 [twice] for c/o of abdominal pain of 6/10 [six on a zero-to-ten scale]. She states the abdominal pain is the same pain she had when she was hospitalized.” *A progress note entered on 9/19/25 at 3:16 p.m. by RN G stated, “PRN oxycodone administered today x2 for c/o abdominal pain 6/10. She [resident 7] states the abdominal pain is the same pain she had when hospitalized.” *A progress note entered on 9/20/25 at 3:59 p.m. by LPN O stated, “Resident [resident 7] does verbalize pain and discomfort frequently and asks for prn pain medication.” *On 9/20/25, she received two doses of PRN oxycodone 5 mg. *On 9/21/25, she received two doses of PRN oxycodone 2.5 mg. *On 9/22/25, she received three doses of her PRN oxycodone 2.5 mg and one dose of 5 mg oxycodone.	F0697		

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F0697 SS = G	Continued from page 21 *A progress note entered on 9/23/25 at 11:22 p.m. by RN Q stated, “Resident [resident 7} concerned stated her lower abdomen is getting bigger. Stated she wants to be seen by [a] specialist.” *On 9/23/25, she received three doses of her PRN oxycodone 2.5 mg and one dose of 5 mg oxycodone. *A progress note entered on 9/24/25 at 10:52 a.m. by LPN O stated, “Resident [resident 7] utilizes prn oxycodone and prn acetaminophen for c/o pain; reminded [her] to reposition as she lays in bed most of the day. Resident satisfied with pain regime.” *On 9/24/25, she received three doses of PRN oxycodone 5 mg. -At 3:30 a.m., LPN Z administered one of those 9/24/25 doses and documented resident 7’s pain rating was 0/10. *A progress note entered on 9/24/25 at 3:33 p.m. by RN Q stated, “Check resident [resident 7] for eve [evening] incoming nurse. She is sleeping but easily awaken. Asked her about her chronic lower abd [abdominal] pain stated she wants more pain med [medication]. Pain rated 10/10. Administer 5 mg [milligrams] oxycodone per tubing. Asked resident if she wants to be seen @ [at] clinic now since rounds visit today was cancelled. Stated she will wait until tom. [tomorrow] a.m [morning]. if [a] Physician will be here.” *A progress note entered on 9/24/25 at 5:43 p.m. by RN Q stated, “[Resident 7's] Daughter is here. Spoke to her, resident concern. Lower abdomen is getting bigger having a lot of pain rated 10/10. Administer PRN oxycodone 5 mg. Offered resident to go to ER [emergency room] to be seen there. Agreed. Refuses to go with ambulance. Her daughter transported her to the [Avera Flandreau Hospital] hosp. [hospital] ER. *A progress note entered on 9/24/25 at 11:50 p.m. by RN Q stated, “Resident was sent to SF [another town] per [Avera Flandreau Hospital] ER (emergency room).” *A progress note entered on 9/25/25 at 8:18 a.m. by director of nursing (DON) B stated, “Spoke with RN on Oncology unit, stated that resident [resident 7] has been admitted [to the facility].” 3. Interview and record review on 9/24/25 at 4:30 p.m with social services designee E revealed:	F0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435086**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/25/2025**
NAME OF PROVIDER OR SUPPLIER **RIVERVIEW HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **611 EAST 2ND AVE , FLANDREAU, South Dakota, 57028**	

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F0697 SS = G	Continued from page 22 *A progress note dated 9/23/25 at 11:22 p.m. had no writing in it. *Social service designee E reported that she had not finished the note, but it was because resident 7 had notified her of increased pain. 4. Interview on 9/24/25 at 4:35 p.m. with registered nurse (RN) Q regarding resident 7’s pain revealed: *She was concerned about resident 7's pain because the resident frequently reported a pain level of six on a zero-to-ten scale and rated her pain that day at ten. *She stated ”Today is the first day she [resident 7] has been like this." 5. Interview on 7/25/25 at 9:52 a.m. with RN G regarding resident 7’s pain revealed: *She felt resident 7 was "tough to read", was anxious and "always" rated her pain at six on a zero-to-ten scale. *After resident 7 got Tylenol (medication for mild pain) or Oxycodone (a prescription for moderate to severe pain), she would say that her pain was better. 6. Review of the provider’s 6/2025 pain management policy revealed: *”Policy Statement: It is the policy of this center that resident’s receive care to attain and maintain the highest quality of care and life.” *”4) 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 PAINAD (Pain Assessment in Advanced Dementia).” *”6) If it is determined that pain is not controlled to the resident satisfaction, the medical provider is consulted, and the resident remains on alert charting.”	F0697		
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F0760	1. All residents have the potential to be affected.	9-30-25

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F0760 SS = G	Continued from page 23 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incidents (FRIs), interview, record review, and policy review, the provider failed to ensure medications were available and administered to: *One of one sampled resident (2) who did not receive physician-ordered anti-seizure medication for five doses and who had increased seizure episodes that resulted in the resident's transfer to the emergency department. *One of one sampled resident (4) who did not receive his physician-ordered blood clot preventing medication for 7 days Findings include: 1. Review of the provider's SD DOH FRI received on 9/3/25 revealed: *Resident 2 did not receive five doses of his physician-ordered scheduled anti-seizure medication. *On 9/2/25, resident 2 had seizures that lasted longer than five minutes. *He was sent to the emergency department (ED) for evaluation due to his increased seizure activity. 2. Review of resident 2's electronic medical record (EMR) revealed. *He had orders to receive Zonisamide (a medication to treat seizures) 100 milligrams (mg)/5 milliliters (ml) scheduled twice daily at 8:00 a.m. and 8 p.m. *On 8/30/35 at 8:00 p.m., RN I administered resident 2's Zonisamide. *On 8/31/25 at 8:00 a.m., CMA P documented resident 2's Zonisamide was not administered and it was "On Order From Pharmacy". *Resident 2's subsequent four scheduled doses of Zonisamide were documented as not administered and it was "On Order From Pharmacy".	F0760	2. PharMerica added anti-seizure medications to the RX now, ekit, on 9-25-2025. Resident 2's MAR was audited and Neurology MD verified. 3. All nursing staff, who administer medications and order medications, were educated on the ordering process when medication cards are almost completed, medication errors and examples of medication errors to include omitted doses: failure to give a scheduled medication, and many other examples, was completed on 9-29-25 and 9-30-25. All staff not in attendance will be educated on their next shift scheduled. 4. DNS or designee will audit 5 residents to ensure medications were given per order, and if medication on order, was it ordered in a timely manner, and these will be done weekly times for four weeks then monthly times for two months. DNS can view medications ordered and received in View Master, a PharMerica website. 5. DNS or designee to complete audits weekly times four weeks, then monthly times two months to ensure medication carts are audited to check medication carts with current orders, medications are ordered in a timely manner if no overstock on cart and View Master(PharMerica RX website) is being reviewed to ensure medications are on order or being delivered.	9-30-25

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F0760 SS = G	Continued from page 24 3. Interview on 9/23/25 at 4:20 p.m. with registered nurse (RN) G revealed: *Residents' medications were to be ordered when the supply of a medication was depleted. *She reported that if medications did not arrive on time, there were medications available in an emergency kit. 4. Interview on 9/24/25 at 10:45 with certified medication aide (CMA) R revealed: *She was working her first week as a CMA. *She was trained to re-order residents' medications after she administered the last dose of medication. *She demonstrated how to re-order medications in the facility's electronic documentation system, Point Click Care (PCC). 5. Interview on 9/24/25 at 11:00 a.m. with licensed practical nurse (LPN) X revealed: *She had worked at the facility for approximately three weeks and was trained to re-order a resident's medication when there were eight pills left. -She explained that the last column on a medication card was highlighted in blue to remind staff to re-order the medication. *She demonstrated how to re-order medications in PCC. 6. Interview on 9/24/25 at 2:32 p.m. with LPN O revealed: *She would re-order medications when a resident's supply of medication had three days of doses left. *She did not feel it was appropriate to wait until the last dose had been administered to re-order a resident's medications. 7. Interview on 9/25/25 at 9:35 a.m. with RN N revealed: *She was a contracted travel nurse who worked at the	F0760	6. DNS or designee to audit random medication pass to ensure residents are getting and taking medications, weekly times four weeks, then monthly times two months. 7. DNS or designee will bring the audits to the next montlhy QAPI committee meeting for review and recommendations to continue or to discontinue audits.	9-30-25

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F0760 SS = G	Continued from page 25 facility for approximately a month, but had worked at the facility previously. *She ordered the medication when she removed the last dose for administration from a resident's medication supply. *She did not recall any problems with pharmacy not delivering medications timely. 8. Follow-up interview on 9/25/25 at 9:52 a.m. with RN G revealed: *She re-ordered medications when there were eight doses left. *For a liquid medication not marked with a reminder to re-order, she stated “I use my better judgement. I don’t wait until the last dose.” *She felt that resident 2’s medication should have been re-ordered before it was depleted. 9. Interview on 9/25/25 with director of nursing (DON) B revealed se expected staff would re-order residents' medications before they were depleted to ensure doses were not missed. 10. Interview on 9/25/25 at 1:25 p.m. with pharmacy director S revealed: *The pharmacy recommended that medications be re-ordered when there was a three-day supply of the medication remaining. *She recalled that resident 2’s medication was requested to be filled by fax on Sunday 8/31/25. -The pharmacy’s fax machine was not checked on Sundays. *She explained that Monday 9/1/25 was a holiday and the pharmacy's fax machine would not have been checked that day. -There was a phone number for staff to call to re-order medications. *It was her opinion that resident 2 missing five doses of his anti-seizure medication was a significant medication error due to the type of medication and the outcome of resident 2's seizure episodes, followed by	F0760		

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F0760 SS = G	Continued from page 26 the resident's transfer to the ED. 11. Review of the facility's medication re-order sheet from 8/31/25 revealed: *A request for a refill of resident 2’s Zonisamide. -with comments that included “Total Quantity Remaining-0, Unable to give this morning. Next [dose] due [on] 8/31/25 [at] 2000 [8 p.m.]. *The bottom of the medication reorder sheet included instructions to, “*Please reorder medication in advance (3 day minimum) of need to assure an adequate supply is on hand.*” 12. Review of the provider's SD DOH FRI received on 8/13/25 revealed: *Resident 4 did not receive his coumadin, a blood thinning medication used to prevent blood clots from 8/7/25 through 8/12/25. *The provider reported that the resident's coumadin medication was unavailable due to an updated lab schedule. 13. Review of resident 4's EMR revealed: *Resident 4 was to receive Coumadin every day to prevent blood clots. *There was no administration of Coumadin from 8/7/25 through 8/12/25. 13. Interview on 9/23/25 at 4:20 p.m. with registered RN G regarding resident 4's missed doses of coumadin revealed: *She reported that resident 4 had recently had a change in his lab schedule to determine is dose of Coumadin. -The order was changed from every week to every two weeks and pharmacy must not have been notified. -The pharmacy would adjust resident 4's Coumadin dose each week based on his lab values. -Because there were no new lab values, pharmacy did not re-order the resident's Coumadin.	F0760		

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F0760 SS = G	Continued from page 27 *She stated “Something definitely should have been done.” -She did not say exactly what should have been done. 14. Review of the provider’s January 2022 medication ordering and receiving from pharmacy provider policy revealed: *Procedure, Section 1. C, “All medications shall be reordered in advance by writing the medication and prescription number, or applying the peel-off bar coded label from the prescription label on the reorder sheet and faxing or otherwise transmitting the order to [the] pharmacy.”	F0760		