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 03/25/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/23/26 through 3/25/26. Areas surveyed included dietary services, allegations of potential resident abuse and neglect, and resident safety related to a resident's expressed suicidal ideations and a resident's fall from a mechanical full body lift. Riverview Healthcare Center was found not in compliance with the following requirements: F600 and an immediate jeopardy violation at F689.	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 South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and observation, the provider failed to protect a resident's right to be free from potential neglect by one of one certified medication aide (CMA) (N) who left one of one sampled resident (2) unattended on the toilet for about two hours. Resident 2 was identified at risk for falling and developing pressure ulcers (skin and/or underlying tissue injury from prolonged pressure), and needed staff assistance with	F0600	Corrective action was taken for Resident #2 who was assessed by licensed nursing staff following the incident on 4/9/26 with a skin and pain assessment, and no new injuries were identified beyond previously documented concerns. The resident's care plan was reviewed and updated by IDT. Staff involved in the incident were terminated. A facility-wide audit on 4/9/26 was conducted on all residents requiring toileting assistance to ensure care plans accurately reflect supervision needs, staff response expectations, and safety interventions. All staff were educated by "directed inservice" on abuse, neglect, and involuntary seclusion definitions, resident supervision expectations during toileting, call light response expectations, and resident rights related to dignity and safety by Administrator/Designee. Updates with care plans done as needed based on audit results. Resident head counts are completed on every shift by Charge Nurse, by validating on resident census document. Education included review of the incident involving a resident left on the toilet for a prolonged period and reinforcement of expectations that residents are not to be left unattended for those residents needing supervision. All staff who are n o t presently educated will be prior to their next scheduled shift. Administrator will perform observational audits of staff performing head count audits weekly for 4 weeks and monthly x2 monthly. The results of these audits will be brought to the monthly QAPI meeting for review and recommendation.	4/15/2026

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	
Christina Konechne	Administrator	4/17/26

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F0600 SS = G	Continued from page 1 the use of a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) to transfer on and off the toilet. That failure resulted in the resident having reddened skin on his buttocks with risk for that area developing into a pressure ulcer. Findings include: 1. Review of the provider's 2/9/26 final SD DOH FRI revealed that resident 2 was found sitting on the toilet in the beauty shop bathroom at around 4:20 p.m. on 2/7/26. He required the use of the sit-to-stand lift for transfers, and that lift was left attached to the resident. The door was closed, and the call light was not activated. Before that, a certified nurse aide (CNA) on the evening shift saw that resident 2's room call light was on, but resident 2 was not in his room. That CNA turned off resident 2's room call light and proceeded to answer other resident's call lights down that same hallway. The charge nurse found resident 2 sitting on the toilet in the beauty shop bathroom at around 4:20 p.m. on 2/7/26. She assisted him off the toilet, helped with personal hygiene, and assessed him for pain and skin injuries. Resident 2 denied experiencing any pain. His buttocks had slight redness "consistent with the seat of the toilet," that was "due to prolonged sitting for an unknown time on the toilet." The redness "subsided [resolved] before the end of the shift." The provider's investigation concluded that CMA N assisted resident 2 to the beauty shop bathroom sometime between 2:15 p.m. and 2:30 p.m. on 2/7/26 as that was when resident 2's wife witnessed CMA N and her husband head towards the beauty shop bathroom before she left for the day. CMA N denied that he assisted resident 2 to the beauty shop bathroom, although there were witnesses who confirmed seeing him take resident 2 to that bathroom. CMA N did not inform any other staff member that he had taken resident 2 to the beauty shop bathroom before the end of his shift. The provider suspended CMA N's employment on 2/9/26 pending further investigation when CMA N was identified as the staff member who left resident 2 on the toilet by resident 2's wife. The provider initiated staff education related to "abuse/neglect policy and resident cares." Education	F0600		

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F0600 SS = G	Continued from page 2 was continued regarding "Assisting Residents with Toileting needs, to include remaining with residents that require close supervision." Additional staff education to the CNA's and nurses was initiated regarding "Shift Hand off/Report [the shift leaving gives a verbal report to the oncoming shift while walking and seeing each resident and his/her location] during change of shift to include head count of residents of assigned units." A sign reading "vacant" and "occupied" was added to the outside of the beauty shop door to indicate to staff when the beauty shop bathroom was in use. Lastly, the provider terminated CMA N's employment with the facility. 2. Review of resident 2's electronic medical record (EMR) revealed his 1/7/26 Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated his cognition was moderately impaired. Resident 2's care plan included that he required the use of a sit-to-stand lift for transfers, "maximal/substantial" transfer assistance while using the toilet, and he was dependent on the staff for toileting hygiene. There was a focus area that read, "I have the potential for pressure ulcer development related to immobility, incontinence." The associated goal read, "I will have intact skin, free of redness, blisters, or discoloration by/through [the] review date." Resident 2's 1/6/26 Braden scale (a tool used to assess the risk of developing pressure ulcers) assessment score was 13, which indicated he had a moderate risk for developing pressure ulcers. Resident 2 had diagnoses of Parkinson's disease (a brain disorder that damages movement-control cells, causing shaking, stiffness, slow movements, balance and mood problems), unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities), hallucinations (to see, hear, smell, taste or touch something that is not there), and unspecified sensorineural hearing loss (a hearing loss caused by damage to the inner ear or auditory nerve, with no known specific cause). Resident 2's 9/3/25 Morse fall scale (a tool for assessing a patient's risk for falling) assessment score was a 75, which indicated he had a high risk for	F0600		

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F0600 SS = G	Continued from page 3 falling. There was no documented pain assessment or skin assessment after resident 2 was left on the toilet for an extended period on 2/7/26. 3. The surveyor team was not able to interview resident 2 during the survey from 3/23/26 to 3/25/26 due to the resident sleeping or being unavailable during attempted interview times. 4. Interview on 3/24/26 at 8:59 a.m. with CNA C revealed she checked on her assigned residents every two hours. These checks included assisting residents to reposition if they were not able to reposition themselves. If she assisted a resident to the bathroom, she would give them five to ten minutes of privacy and then go back to check on them if the resident had not used their call light to ask for assistance. She said she checked on them at this time frame because if a resident sat on the toilet any longer, they would get redness from the pressure of sitting on the toilet seat too long. 5. Interview on 3/24/26 at 9:18 a.m. with CNA E revealed that some resident's bathrooms were not big enough to maneuver for the sit-to-stand or the full-body lift (a mechanical lift and sling used to lift a person's full body). If a resident needed to use the bathroom and their bathroom was too small for the transfer equipment, the staff were to take those residents to the beauty shop bathroom. CNA E stated that there was no specific process or policy about when the CNAs were expected to go back to assist the resident after they were transferred onto the toilet. She would assist them on the toilet, and then she "just remembers to go back for them" and assist them off of the toilet. 6. Observation on 3/24/26 at 2:27 p.m. revealed a staff member transferred a resident into the beauty shop, then closed the door behind them. That staff member did not change the sign on the door from "Vacant" to "Occupied" before shutting the door. 7. Review of the provider's investigation documentation for the 2/7/26 incident revealed education on the abuse and neglect policy had previously been initiated on	F0600		

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F0600 SS = G	Continued from page 4 2/1/26 related to a previous complaint survey citation. That education was ongoing through 3/2/26 to ensure that all staff received the education. There was no documentation to support that ongoing audits were completed to ensure the staff understood resident safety interventions and the education that they were provided, or documentation that the provider ensured no other residents were left on the toilet at the time of the incident. 8. Interview on 3/24/26 at 5:45 p.m. with administrator A revealed that she confirmed there were no audits completed after the incident involving resident 2 on 2/7/26. 9. Review of the provider's March 2025 Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation policy revealed that "Neglect" was defined as "Failure of the Center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in physical harm, pain, mental anguish, or emotional distress." The policy included procedures for conducting a thorough investigation, protecting other residents from potential abuse or neglect, and coordinating how the staff were to report potential abuse or neglect situations with the provider's Quality Assurance and Performance Improvement (QAPI) program.	F0600		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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.	F0689		

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F0689 SS = SQC-J	Continued from page 5 This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, interview, observation, record review, and policy review, the provider failed to ensure residents were protected from risk of injury or harm by certified nursing assistants (CNAs) who failed to safely use total body lift devices (a mechanical lift and sling used to lift a person's full body) for two of two sampled residents (1 and 3), who needed the assistance of two staff members to transfer between surfaces. Contracted travel CNAs I and H failed to safely transfer resident 1 from her wheelchair to her bed using the total body lift. CNAs K and L failed to use a compatible sling type to transfer resident 3 using the total body lift. That failure put all residents, who needed staff assistance with the use of a lift for safe transfers, at risk for falling, injury and/or serious harm. Immediate Jeopardy (IJ) at F689, scope and severity J, began on 2/26/26 at 5:40 p.m. when resident 3 was lowered to the floor during a transfer from her wheelchair using a full body lift by CNAs K and L. Resident 3 had a full body lift sling in her room that was brought with her from the hospital when she admitted to the facility earlier that same day. Resident 3's family members handed the sling to CNAs K and L, who placed it under resident 3. As one of the CNAs began placing the sling straps of the lower body portion of the sling to the corresponding hooks on the full body lift, resident 3 started to move around and slid forward in the sling. The CNAs readjusted the resident in the sling and attached the rest of the sling onto the full body lift hooks. Resident 3 continued to move around in the sling and slid forward towards the edge of the wheelchair seat, causing the sling to tilt in a downward position. CNAs K and L could not complete the transfer, and instead lowered resident 3 to the floor. Resident 3's buttocks made first contact with the floor, and then she was assisted to a lying position. Resident 3 did not hit her head but did express pain to her ribs. She received a chest X-ray on the morning of 2/27/26. The X-ray did not show any breaks or fractures. The provider indicated in the FRI that "staff [were] educated regarding resident transfers, staff competency regarding transfers initiated and ongoing, audit of	F0689	Resident 1 was assessed by DON after surveyors witnessed two cnas improper use of mechanical lift on 3/24/26. Resident 1 was noted to have a 2.5cm x 4cm erythema area to right forearm during this assessment. Resident 1 had no complaints of pain at this time. Nursing will monitor area until resolved. Physician, Resident 1's son and Hospice were notified of incident. Administrator will review all education and competencies to ensure nursing staff current and new employees/agencies know appropriate mechanical lift and sling size for each resident. Residents that require mechanical lift were audited and reviewed by IDT on 3/24/26 to ensure proper mechanical lift, proper sling size on care plan and adequate number of slings in place that are needed for. Care plans were updated to reflect any changes identified. All mechanical lifts were inspected by maintenance for proper function on 3/25/26. DON and Senior Director of Nursing inspected slings to ensure adequate number of slings and back up slings on hand in case sling becomes soiled on 3/25/26. Administrator and Senior DON verified each resident that has appropriate assigned sling with name on sling, stored in their room with back up slings available if needed on 3/25/26. All resident labeled slings are stored in resident room. All extra slings are stored in beauty shop, 2nd floor. Education, return demonstration, competency was completed, and manufacturing recommendations of appropriate sling size education by by DON on 3/24/26 initiated at 10:00pm for all nursing staff on duty this evening regarding proper use of mechanical, proper sling size, where sling can be found and location of extra slings in case slings become soiled. Agency CNA 1 that was involved in the incident was educated during last night's evening shift on 3/24/26. Agency CNA 2 will be educated and competence completed prior to her next scheduled shift, which as this time is Thursday 3/26/26. Rock Medical and Interim Healthcare were notified of the IJ citation on 3/25/26 involving their staff. DON and Administrator will collaborate to schedule a manager at the beginning of each shift for "directed in service" education, return demonstration, manufacturing recommendations, competency of Nursing staff including current nursing staff, prn nursing staff, any agency staff prior to next shift, this education will remain ongoing. This education will be implemented in the onboarding process for all new staff. Administrator will perform observational audits every new admission to ensure proper mechanical lift and sling is appropriate on care plan based on height and weight. Additional observational audits will be completed by Administrator/Designee randomly for proper use of mechanical lifts, appropriate sling size and type, as well as care plan updated appropriately. Both audits will be completed 3 times a week for 4 weeks and weekly for one month thereafter to ensure ongoing compliance. Results of these audits will be reviewed in monthly QAPI for review and recommendation.	3/26/2026

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F0689 SS = SQC-J	Continued from page 6 resident appropriate total body lift sling size initiated and ongoing." Interviews with staff throughout the survey from 3/23/26 to 3/24/26 revealed they did not recall any recent education or competencies related to safe transfers with total body lift and sit-to stand lift (a mechanical lift used to assist from a seated to a standing position) - If not mechanical, then (a manual lift used to assist from a seated to a standing position)use and they were unaware of which sling to use for specific residents. Record review revealed that CNAs K and L, and other direct care staff, did not complete the total body lift or sit-to-stand lift competencies after the incident on 2/27/26 and both worked shifts since then. Further review of staff education and competencies revealed that not all direct care staff had competencies completed related to using mechanical lifts as described in the provider's FRI. Observation on 3/24/26 at 3:40 p.m. of contracted travel CNAs H and I while transferring resident 1 using the full body lift revealed they used the burgundy-colored sling (size large). CNA I was on resident 1's left side, while CNA H was on her right side. CNA I was facing resident 1 and looped her left arm under the resident's left arm. CNA I used her right arm to lean resident 1 forward in the wheelchair. CNA H then placed the burgundy sling behind the resident and resident 1 leaned back in the wheelchair. The CNAs pulled the lower straps of the sling towards and under the resident's thighs and interlaced the straps to secure the resident in the sling. CNA H told resident 1 to "give herself a hug." Resident 1 crossed her arms, while both CNAs discussed what color loops to use. The black loops (the innermost loop) on the upper shoulder straps were used and attached to the full body lift, and the green loops (the middle loops) on the thigh straps were used and attached to the full body lift. CNA H added the burgundy loop (outer-most loop) on the right thigh strap to the full body lift. Resident 1 reached up to grab the crossbar of the full	F0689		

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F0689 SS = SQC-J	Continued from page 7 body lift and CNA H told resident 1 to "hug herself" again. CNA I was operating the lift controls to lift the resident while CNA H was holding on to the back handle of the sling to stabilize resident 1. Resident 1's wheelchair pad and the left handle of the wheelchair were caught on the lift sling, and it lifted the wheelchair off the floor with the resident in it. While the resident and her wheelchair were still in the air, CNA H pulled on the wheelchair pad, which was between the resident and the sling, to release the pad from the sling. The CNAs then noticed that the wheelchair was also caught in the sling. CNAs H and I switched tasks while the resident and the left side of her wheelchair were suspended in the air. CNA H lowered the resident and her wheelchair using the lift control until her wheelchair was back on the floor, while CNA I wrapped her arms around the back of the wheelchair and pulled resident 1 in her sling to guide her back into the wheelchair. Once resident 1 was seated in the wheelchair, CNA I released the left handle of the wheelchair from the sling strap. CNAs H and I did not reposition resident 1's sling before lifting her up again. The bottom of the sling (that was to be placed under the resident's bottom) was positioned at her mid-back. Once resident 1 was lifted in the air, CNA I stated, "Let's hurry and get her in there [the bed], this is all wrong." CNA H then moved the full body lift and resident 1 suspended in the lift sling over to the bed and lowered her onto the bed. Record review revealed CNA I had a mechanical lift competency performed on 3/2/26, but there was no documentation that CNA H had a competency completed since resident 3's FRI accident on 2/27/26. Record review revealed the mechanical lift sling size was not identified on the resident's care plan (personalized plan that addresses a resident's care needs, goals, and interventions) or the Kardex (a report of the resident's care needs and interventions) for at least five sampled residents who utilized mechanical lifts (residents 1, 2, 6, 7, and 8). Administrator A, special projects administrator Q, and registered nurse (RN) clinical liaison P were notified of the IJ on 3/24/26 at 6:30 p.m., and an IJ removal	F0689		

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F0689 SS = SQC-J	Continued from page 8 plan was requested. The initial removal plan was received on 3/24/26 a.m. at 10:39 p.m. by email. The edited removal plan was received on 3/25/26 at 11:36 a.m. An additional edit was received on 3/25/26 at 2:27 p.m. The final edit was made on 3/25/26 at 2:47 p.m. The removal plan was accepted on 3/25/26 at 2:49 p.m. by email and phone call. The IJ was removed on 3/25/26 at 5:15 p.m. as confirmed by onsite verification by the survey team. After the IJ removal, the scope and severity of the non-compliance remained at a D. The census was 57. Findings include: 1. Review of the provider's 2/26/26 SD DOH FRI involving resident 3 revealed that CNAs K and L were using a full body lift to transfer the resident from her wheelchair to her bed using a lift sling that the resident's family had brought to the facility. Due to the resident repositioning herself in the sling, the CNAs could not safely complete the transfer, and the CNAs lowered resident 3 to the floor using the upper portion of the sling while the lower portion of the sling was attached to the lift, as described above. 2. Review of resident 3's electronic medical record (EMR) revealed her 2/26/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. Resident 3's diagnoses included cellulitis of bilateral lower limbs (a painful red bacterial skin infection on both lower legs), chronic kidney disease stage 3 (when kidneys are damaged, filter blood poorly, causing waste buildup), lymphedema (swelling caused by a buildup of lymph fluid in the body between the skin and muscle), atrial fibrillation (when the heart's upper chambers beat too fast and irregularly), polyneuropathy (damaged peripheral nerves, causing numbness, weakness, tingling), and hypertension (high blood pressure). Resident 3's diagnoses included cellulitis of bilateral	F0689		

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F0689 SS = SQC-J	Continued from page 9 lower limbs (a painful red bacterial skin infection on both lower legs) and polyneuropathy (damaged peripheral nerves, causing numbness, weakness, and tingling). Resident 3's 2/26/26 Morse fall scale (a tool for assessing a patient's risk of falling) assessment score was 60, which indicated that she was had a high risk for falling. Resident 3's care plan indicated that she was to be transferred by two staff members with the use of a "mechanical lift [a mechanical lift used to assist from a seated to a standing position or a mechanical lift and sling used to lift a person's full body]." Neither her care plan nor the Kardex included the type of lift (full body lift or sit-to-stand lift) or what sling size the staff was to use when assisting her to transfer. 3. Interview on 3/24/26 at 8:59 a.m. with CNA C revealed that she would choose the size of the mechanical lift slings based on the size of the resident's body. The smaller-bodied residents would get a medium or a smaller sized sling, and the larger-bodied residents would get a larger sling size. She said that new staff members needed to ask other staff members to know which sling size to use for which resident, or by referring to the Kardex information. 4. Interview on 3/24/26 at 9:12 a.m. with RN D and licensed practical nurse (LPN) J revealed that the information on the mechanical lifts and the lift slings was stored in two binders at the nurse's station. However, RN D could not find those binders. She asked LPN J where those binders were, but LPN J did not find them at the nurse's station either. LPN J found information on total body lifts in director of nursing (DON) B's office, and she said that the information was usually available for staff at the nurse's station. 5. Interview on 3/24/26 at 9:18 a.m. with CNA E revealed that she had worked at the facility for the past month. She did not receive any training on the safe use of the mechanical lifts at the facility. She previously worked at other nursing homes and relied on the training she received at those facilities. She stated that she chose the resident's lift sling size based on the resident's body type. She stated there was no resource she referred to help her determine the	F0689		

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F0689 SS = SQC-J	Continued from page 10 resident's correct sling size to use. She stated, "I just go based on what the resident looks like by their body type and guess." 6. Review of the EMRs for residents 1, 2, 6, 7, and 8 revealed that neither their care plans nor their Kardex contained information on what sling sizes the staff needed to use for their transfers. Resident 1's care plan and Kardex revealed she required two people to assist her with transfers, but there was no indication about what type of equipment to use when transferring her. 7. Interview on 3/24/26 at 9:45 a.m. with CNA M revealed she completed a training refresher course four years ago on how to work a mechanical lift at the facility but did not receive recent lift use training. She stated she chose the mechanical lift sling size based on the body size of the resident. She was unable to locate documentation that indicated what size sling to use for each resident who utilized the mechanical lifts. 8. Interview on 3/24/26 at 10:45 a.m. with RN O revealed that she chose the size of the lift sling based on the body size of the resident. At that time, RN D, CNA E, and CNA C all began looking in the red communication binder at the nurse's station. They then found a paper dated 10/28/25 with resident sling size information on it. RN O stated, "Well, this isn't updated at all." 9. Interview on 3/24/26 at 11:10 a.m. with RN F revealed that she did not know what the residents' mechanical lift sling sizes were. She would ask a CNA to help her and to tell her which sling size to use. 10. Interview on 3/24/26 at 3:58 p.m. with CNA I regarding the transfer with resident 1 observed on 3/24/26 at 3:40 p.m. above revealed that she stated the transfer was "not good." She explained that it was hard to get the sling positioned under the resident. The resident was moving, and the CNAs had to pull up hard to get the sling in the correct position under her legs. She thought that the sling was too big for resident 1, and it was mispositioned. She stated, "I know the sling	F0689		

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F0689 SS = SQC-J	Continued from page 11 size based on the resident's body, but this sling was too big for her. She needs a different size and a different type of sling. One that cradles her more. She needs a medium sling." 11. Interview on 3/24/26 at 4:35 p.m. with CNA H regarding the above observed transfer with resident 1 revealed that the sling should have been tucked under the resident more. She was worried when the wheelchair was caught in the sling because the resident was confused, moving, and grabbing "at everything." She indicated that she "just knew" the resident's sling size based on "whatever sling is in the room." If a sling in a resident's room did not look right, she would look for another sling to use based on the resident's body size. 12. On 3/24/26 at 6:30 p.m. administrator A, special project administrator Q, and RN clinical liaison P were notified of the IJ. On 3/24/26 at 10:39 a.m., the initial removal plan was received by email. An edited removal plan was received on 3/25/26 at 11:36 a.m., 2:27 p.m., and 2:47 p.m. The removal plan was accepted on 3/25/26 at 2:49 p.m. by email and phone call. REMOVAL PLAN: "Resident [1] was assessed by [DON B] after surveyors witnessed two [CNAs] improper use of mechanical lift on 3/24/26. [Resident 1] was noted to have a 2.5cm x 4cm erythema [reddened skin] area to right forearm during this assessment. [Resident 1] had no complaints of pain at this time. Nursing will monitor area until resolved. Physician, [resident 1's] son and Hospice notified of incident. [Administrator A] will review all education and competencies to ensure nursing staff current and new employees/agencies know appropriate mechanical lift and sling size for each resident. Residents that require mechanical lift were audited and reviewed by [interdisciplinary team] on 3/24/26 to ensure proper mechanical lift, proper sling size on [care plan] and adequate number of slings in place that are needed for. [Care plans] were updated to reflect any changes identified. All mechanical lifts were inspected by maintenance for proper function on 3/25/26. [DON B] and Senior Director of Nursing	F0689		

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F0689 SS = SQC-J	Continued from page 12 inspected slings to ensure adequate number of slings and back up slings on hand in case sling becomes soiled on 3/25/26. [Administrator A] and Senior DON verified each resident that has appropriate assigned sling with name on sling, stored in their room with back up slings available if needed on 3/25/26. All resident labeled slings are stored in resident room. All extra slings are stored in beauty shop, 2nd floor. Education, return demonstration and competency were completed by [DON B] on 3/24/26 initiated at [10:00 p.m.] for all nursing staff on duty this evening regarding proper use of mechanical, proper sling size, where sling can be found and location of extra slings in case slings become soiled. [CNA I] that was involved in the incident was educated during last night's evening shift on 3/24/26. [CNA H] will be educated and competence completed prior to her next scheduled shift, which as this time is Thursday 3/26/26. [CNA H and I's staffing agencies] were notified of the IJ citation on 3/25/26 involving their staff. [DON B] and [administrator A] will collaborate to schedule a manager at the beginning of each shift for education, return demonstration and competency of Nursing staff including current nursing staff, clipboard, prn nursing staff, any travel staff prior to next shift. Request made to Clipboard for customized education to be completed in onboarding process through their platform. DON was at facility on 3/25/26 prior to 6:00am shift for education and competency for nursing staff. [Administrator A] will perform observational audit every new admission to ensure proper mechanical lift and sling is appropriate on care plan based on height and weight. Additional observational audits will be completed Randomly for proper use of mechanical lifts and appropriate sling size and type. Both audits will be completed 3 times a week for 4 weeks and weekly for one month thereafter to ensure ongoing compliance. Results of these audits will be reviewed in monthly [Quality Assurance and Performance Improvement] for review and recommendation. This removal plan asserts that the likelihood for serious harm to any recipient no longer exists by 3/25/26." 13. Review of the provider's updated list of transfer equipment to be used for each resident and observations of slings in residents' rooms on 3/25/26 beginning at	F0689		

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F0689 SS = SQC-J	Continued from page 13 3:30 p.m. revealed that two of the thirteen slings that were in the residents' rooms did not match the updated list or the Kardex information. Resident 5's sling in his room was an extra-large size, and the updated list reflected the same. However, resident 5's Kardex listed that his sling was supposed to have been a size large. Resident 6's sling in his room was size large, and his Kardex reflected the same. However, the updated list indicated that his sling was supposed to have been a size extra-large. 14. Interview on 3/25/26 at 4:35 p.m. with DON B revealed that she was going to review the inconsistencies of the sling information on residents 5 and 6 and update them with the correct sling size. 15. Observation and record review on 3/25/26 at 5:15 p.m. of resident 5 and 6's slings in their rooms, the resident's Kardex, and the updated list of transfer equipment to be used for each resident revealed the discrepancies were fixed and the immediacy was removed. 16. Review of the operator's instructions for the EZ Way Smart Lift (total body lift) 500, 600 & 1,000 lb. (pound) capacities revealed that when transferring a patient from a chair, wheelchair, or toilet, the first step is to position the sling under the resident, the second step is to position the EZ Way Smart Lift near the resident, the third step is to attach the sling to the lift, and the fourth step is to lift the resident upwards. Before fully lifting the resident, the instructions indicated to "push the UP button on the hand control to initiate the upward motion of the lift. Continue the upward motion until there is tension on the legs of the sling, making sure all the loops on the sling are securely hooked on the hanger bars. Smooth the sling legs under the [resident's] thighs with a slight pull on the outside seam of the sling legs, if necessary." 17. Review of the EZ Way Sling Sizing Chart revealed that the gray slings were a size "small," would hold a person of 70 to 100 pounds, and the maximum distance from a person's tailbone to the base of their neck was 21 inches. The beige slings were a size "medium," would hold a person of 90 to 220 pounds, and the maximum distance from a person's tailbone to the base of their neck was 24 inches. The burgundy slings were a size	F0689		

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F0689 SS = SQC-J	Continued from page 14 "large," would hold a person of 190 to 320 pounds, and the maximum distance from a person's tailbone to the base of their neck was 26 inches. The green slings were a size "XL [extra-large]," would hold a person of 280 to 450 pounds, and the maximum distance from a person's tailbone to the base of their neck was 29 inches. The black slings were a size "XXL," would hold a person of 400 to 600 pounds, and the maximum distance from a person's tailbone to the base of their neck was 36 inches. The brown slings were a size "XXXL," would hold a person of 600 or more pounds, and the maximum distance from a person's tailbone to the base of their neck was 37 inches. The sizing chart indicated, "The size/weight designations are merely estimates and basic guidelines. A proper fit will depend on factors other than weight measurements, including the height and girth of a patient [person]. A proper fit will involve the judgment of the caregiver." There was a diagram on how to measure the sling relative to the person that had the following description, "Height of sling – Two inches below Tailbone to top of Shoulder Line…It is important that the base of the sling be positioned two inches below the tailbone and the top of the sling is parallel with the top of the shoulder line (base of neck)."	F0689		

South Dakota Department of Health

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	10620	A. BUILDING: _____ B. WING _____	C 03/25/2026

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S 000	Compliance/Noncompliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/23/26 through 3/25/26. Areas surveyed included environmental safety and the resident call light system. Riverview Healthcare Center was found not in compliance with the following requirement: S451.	S 000		
S 451	44:73:12:41(1-3) Staff Call System The call system must also meet at least one of the following requirements: (1) The call system utilizes fixed call stations that are convenient for resident use and activated by a pull cord or other approved device. The fixed system must actuate a visual signal at the resident room door, and in the clean workroom, soiled workroom, and nourishment station of the nursing unit. In a multicorridor nursing unit, additional visible signals must be installed at each corridor intersection. For the purpose of this subdivision, the term "nursing unit" means a unit that is limited to one floor of a health care facility and has all resident room entrances and exits within sight or control of nursing personnel; (2) The call system utilizes wireless devices that are convenient for resident use and activated by a pull cord or other approved device. The wireless system must actuate a visual and audible signal at the staff station and on pocket paging devices carried by all direct care staff. Wireless devices must be fully supervised, capable of alarm reset at the source, and transmit low battery alert. Wireless devices must utilize batteries that are readily available; or (3) For any other call system, the system must be submitted for review and approved by the department.	S 451	Corrective action was taken for all resident rooms identified during the survey, including Room 118, by immediately assessing each room to ensure call light cords were accessible to residents, and systems were functioning properly, with audible and visual indicators operating appropriately. Any deficiencies identified were corrected at the time of the audit, including ensuring proper function of the call light system components. United Technology completed a facility-wide audit the week of March 30 to verify proper call light function, accessibility, and visibility throughout the building. A one-time call light audit was completed. Findings were corrected. All staff were educated on 4/15/2026 by the Administrator, always ensuring call light accessibility, responding promptly to call lights, verifying call light function, including audible and visual indicators functioning properly, during routine rounds, and proper use of call light system indicators. Monitoring will be completed by maintenance through weekly call light system checks for four weeks and monthly thereafter to ensure continued functionality, including verification of both audible and visual signals. Audits will be reviewed at monthly QAPI to for review and recommendations	4/23/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Christina Konechne TITLE Administrator (X6) DATE 4/17/2026

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S 451	Continued From page 1 A call station or device is not required in the resident room of a cognitively impaired resident, if a nursing assessment determines the resident would not benefit from the availability of a call station or device. The staff call system must include a method for staff to summon assistance if needed. For the purpose of this section, the term "cognitively impaired" means a deficiency that results in a diminished ability to solve problems, to exercise good judgement in the context of a value system, to remember, and to be aware of and respond to a safety hazard. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to ensure the resident call light system made an audible sound when activated for all areas except for one resident room. Findings include: 1. Observation and testing on 3/24/26 at 3:43 p.m. of the resident call light system in room 122 on the facility's second level revealed that when the call light was activated, a light turned on above 122's doorway, and a light turned on at the nurse's station for room 122. There was no audible sound when the resident call light system was activated. 2. Interview on 3/24/26 at 3:45 p.m. with registered nurse (RN) R revealed that she was aware that the resident call light system did not make any sound when activated. She indicated only one resident's room made a sound when the call light system was activated, which was room 118 on the facility's second level. Testing of room	S 451		

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S 451	Continued From page 2 118's call light with RN R at that time revealed a loud buzzing sound emanated from that room when the resident call light system was activated. 3. Observation on 3/24/26 at 3:52 p.m. revealed that a resident entered the beauty shop bathroom. A light turned on above that doorway, and at the nurse's station that indicated the call light in the beauty shop was activated. There was no audible sound when the resident call light system was activated. 4. Interview on 3/25/26 at 6:15 p.m. with administrator A, director of nursing (DON) B, and special projects administrator Q during the exit conference revealed that they were aware that the resident call light system did not make any noise when activated. They were aware of the state rule requiring the resident call light system to make both a visual and an audible signal when activated. They did not know why only room 118 made a sound when that call light system was activated.	S 451		