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	435086	A. BUILDING _____ B. WING _____	C 02/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/12/24 through 2/15/24. Riverview Healthcare Center was found not in compliance with the following requirements: F812 and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/12/24 through 2/15/24. Areas surveyed included care and prevention of pressure ulcers and an animal (dog) that was allowed in the dietary services department. Riverview Healthcare Center was found not in compliance with the following requirement: F812.	F 000		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812	1. Unable to correct deficient practice noted at the time of survey. The kitchen window, food mixer, stainless steel shelves, ventilation hood, refrigerator door, mop boards, the back of the convection oven, the stove and oven, warming oven, microwave oven, and floor of the walk in freezer will all be cleaned by 3/15/24 by ED and dietary staff. The dog bed and dishes were removed by 2/15/24. All opened and non-dated foods were disposed of by 2/16/24. 2. The ED, DM, RD, IC nurse, and medical director reviewed the glove use, hand hygiene, cleaning of equipment policies by 3/11/24. The ED educated all dietary staff on the food storage policy, the sanitation policy and maintaining cleaning records in the dietary department by 3/12/24. All staff not in attendance will be educated prior to their next working shift. The ED is responsible to ensure the cleaning and maintenance are completed. See next page.	3/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Timothy Yeaton* | TITLE: *Executive Director* | (X6) DATE: *3/7/2024*

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F 812	Continued From page 1 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure food safety guidelines were followed by properly storing and labeling food items, not allowing a dog into the food production area, and maintenance of the following equipment in a clean and sanitary manner: *One of three kitchen windows. *One of one food mixer. *Two of two sets of stainless-steel shelves in front of the stove and oven. *One of one ventilation hood. *One of one refrigerator door. *Mop boards throughout the kitchen. *The back of the convection oven, the stove and oven, and the warming oven. *The interior of one of one microwave oven. *The floor of the walk-in freezer. Findings include: 1. Observation on 2/12/24 at 2:00 p.m. during the initial kitchen tour revealed: *A dog bed, food, and water bowls in the kitchen office. The office door opened directly into the food production area of the kitchen. *Approximately twenty-four frosted cupcakes sitting uncovered on the counter. *The window was open and the screen was taped to the frame. There was a layer of dust and dirt on the screen. *A large mixer was on the counter in the corner of the kitchen. It was uncovered and the splashguard had a large amount of dried food particles. *The stainless-steel shelves in front of the stove and oven had a thick layer of food crumbs and a	F 812	3. The ED or designee will audit the cleaning schedules, hand hygiene, glove use and the absence of pets in the kitchen area weekly times four weeks and monthly times two months. The ED or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	

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buildup of unidentified grime.
*The outside and inside of the ventilation hood directly above the stove had a thick layer of dust and grease build-up.
*The refrigerator door edge had a build-up of an unidentified black grime that could be scraped off with a fingernail. The latch to open the refrigerator had a large build-up of black grime
*The mop boards throughout the kitchen were covered with a layer of dirt and food particles.
*The inside of the microwave had a moderate amount of dried food particles.
*The wall behind and the backs of the convection oven, stove and oven, and the warming oven had a thick layer of dust.
*The floor of the walk-in freezer had food packaging debris and food particles present.
*The walk-in refrigerator revealed the following food items were opened without a date:
-A opened squeeze bottle of BBQ sauce .
-A open bag of mozzarella cheese.
-A bag of shredded carrots.
-A bag of parmesan cheese.
-A sliced red onion in a container.
-Cheese slices in a container, not dated.
-Tomatoes slices in a container.
-Lettuce in a container.
-Sliced beef, watery in an open package.
-Cherry cobbler dessert covered with plastic wrap, unlabeled.
-One of two containersof sour cream open, expiration date 3/2024.
*Meat thawing in a pan on the bottom shelf next to a box of oranges and a box of cantaloupes.
*Bacon sitting on the shelf with containers of fruit.
*Two gallons of chocolate milk in a milk crate sitting on the floor in the refrigerator.
*Lunch meat next to buns on the top shelf.
*Two packages of sliced turkey sitting in box on

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the top shelf.
*Cherry cobbler dessert covered with plastic wrap, unlabeled and not dated.
*One of two containers of sour cream open and not dated, expiration dates 3/24.
*A coffee can of old grease sitting on the floor inside of the freezer.
*The dry storage room revealed:
-An opened bag of crispy rice cereal not dated.
-Opened bags of macaroni, not dated.
-An open bag of Tostitos chips, not dated.

2. Observation and Interview with cook G on 2/12/24 at 2:25 p.m. revealed:
*Cook G used a measuring cup stored from the dirty stainless-steel shelf to measure water for food he was preparing.
*Cook G stated the dog was a puppy and had been staying in the kitchen office when DM F was working. A baby gate was used to keep the puppy inside the office.

3. Observation on 2/14/24 at 9:16 a.m. revealed DM F was serving breakfast and his beard was not covered.

4. Observation on 2/14/24 at 11:34 a.m. DM F placed chicken patties with his bare hands in the blender, his beard was not covered.

5. Interview on 2/14/24 at 11:38 a.m. with DM F regarding the kitchen cleaning schedules revealed:
*There were many new kitchen staff that were being trained on proper procedures.
*Food should have been labeled and dated when placed in the refrigerator or the freezer.
*Open packages in the storeroom should have been dated after opening.

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*Weekly cleaning schedules had been not signed off as completed.
*He acknowledged he had a puppy that he and his girlfriend had kept in the office. He stated it was only about 4 days as they had only gotten the puppy on 2/5/24.
*He had started as the DM in December 2023. He was aware of the cleaning needs of the kitchen.
*He had been working on education with the new staff on dating the food items when opened.
*Agreed the food in the walk-in cooler was not stored correctly, regarding the meat and fruit placed on the same shelf.
*There had been no DM in the building for over a year before he started his employment. Between himself, administrator A, and division director of clinical operations (DDCO) I had been making up a plan for cleaning and maintaining the kitchen in a sanitary manner.
*He acknowledged he should wear a beard covering.

6. Interview on 2/14/24 at 2:23 p.m. with an employee who requested to remain anonymous revealed:
*Administrator A had been aware of the puppy in the kitchen and ignored the issue.
*Administrator A had played with the dog in his office.

7. Interview on 2/14/24 at 4:04 p.m. with administrator A revealed:
*He agreed the kitchen needed a thorough cleaning.
*Refrigerated items should have been dated, and placed properly shelves for food safety.

Review of the provider's October 2017 "Food Storage" policy revealed:

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F 812	Continued From page 5 *"Foods stored in walk-in refrigerators and freezers are stored above the floor on shelves, racks. dollies, or other surfaces to facilitate thorough cleaning. Do not line shelving with foil or paper as this prevents airflow." *"Opened items have "use by" dates indicated on them. This "use by" date may be circled to differentiate it from date received or date opened. May indicate date opened or date prepared if required by the survey agency." *"Raw eggs and thawing meats are stored in the refrigerator, preferably on the bottom shelf. Do not store them over ready to eat foods." Review of the provider's September 2019 "Sanitation" policy revealed: *"The Food and Nutrition Services(FANS) Manager maintains completed cleaning schedules for a minimum of 60 days. *Utensils. counters, shelves, and equipment are kept clean, maintained in good repair, and free from breaks, corrosions, open seams, cracks, and chipped areas." *"Kitchen wastes that are not disposed of by mechanical means are kept in clean, leak proof, nonabsorbent, tightly closed containers and are disposed of daily." *"Cleaning schedules are developed by the FANS manager or Person in Charge." *"The FANS manager or Person in Charge monitors compliance to the cleaning schedule."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880	See next page	

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F 880	Continued From page 6 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880	**Corrective Action:** 1. For the identification of lack of appropriate: *Procedural technique, hand hygiene, and glove use during wound care. **The administrator, DON, infection control nurse and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. Please do read 2567 findings.** All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 3/12/24 by DNS or designee. All staff not in attendance will be educated prior to their next working shift. **Identification of Others:** 2. Individual residents and other residents as well as staff have potential to be impacted when inconsistent infection control practices by all facility staff are not done. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 3/12/24 by DNS or designee. All staff not in attendance will be educated prior to their next working shift. **See next page.**	3/15/2024

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F 880	Continued From page 7 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, employee competency review, and policy review, the provider failed to ensure appropriate infection control practices were followed during two of three observed wound dressing changes. Findings include: 1. Observation on 2/13/24 at 9:04 a.m. with registered nurse (RN) C during a wound dressing change for resident 5 revealed she had: *Placed a barrier on the resident's bed. *Performed hand hygiene and put on a pair of gloves. *Removed the resident's shoe and sock and noted there was not a dressing on the wound. *With those same gloves, she:	F 880	**System Changes:** 3. Root cause analysis conducted answered the 5 Whys: Root Cause 1. Anxiety could have been prevented if treatment nurse was more familiar with being observed during treatment process. 2. With more frequent treatment observations, treatment nurse would have been more confident in being observed by surveyors. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. Divisional Director of Clinical Operations contacted the South Dakota Quality Improvement Organization (QIO on 3/6/24 and include brief detail of discussion. Discussed the five ways and root cause analysis and the QIO provided us with some tools for improvement. See next page.	

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F 880	Continued From page 8 -Cleansed the wound with gauze and the wound cleanser. -Discarded the soiled gauze. -Placed calcium alginate [wound dressing] on the wound. -Covered the wound with Optifoam [adhesive bordered wound dressing]. -Put the sock and shoe back on the resident's foot and then discarded the used supplies. *Then removed those gloves and cleansed her hands with hand gel. 2. Observation on 2/13/24 at 12:34 p.m. of RN C while preparing for a wound dressing change revealed she had: *Removed a previously opened package of calcium alginate from a cart drawer. *Removed a pair of scissors from the treatment cart and without sanitizing the scissors, used those scissors to cut a piece from the calcium alginate dressing. *Then placed the scissors back in the treatment cart without sanitizing them. 3. Observation on 2/13/24 at 12:45 p.m. of RN C during a wound dressing change for resident 26 revealed she had: *Performed hand hygiene and put on a pair of gloves. *Removed the residents shoe, sock and a soiled band aid. *Discarded the soiled band aid. *With those same gloves, she: -Cleansed the wound with gauze and the wound cleanser. -Discarded the soiled gauze. -Placed calcium alginate on the wound. -Covered the wound with a band-aid. -Put the sock and shoe back on the resident's	F 880	**Monitoring:** 3. Administrator, DON, and/or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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foot and discarded the used supplies.
*Then removed those gloves and cleansed her hands with soap and water.

4. Interview on 2/13/24 at 12:57 p.m. with RN C regarding the above dressing change observations revealed:
*She was aware she had not performed the appropriate hand hygiene and glove use for both of the observed dressing changes.
*She should have removed the gloves and performed hand hygiene after taking off shoes and after touching the soiled items.

5. Interview on 2/14/24 at 3:08 p.m. with director of nursing B regarding the above dressing change observations revealed she:
*Would have expected the nurse to have completed hand hygiene between the clean and dirty steps and before and after the application of gloves.
*Stated they reviewed the steps of the dressing change process and completed competencies annually with all of the nurses.

6. Review of the provider's LN [licensed nurse] Competency Dressing Change for RN C dated 9/7/23 revealed:
*All steps had a mark in the "Met' column.
*The comment section had "Remember to change gloves between dirty & clean" written in it.
*It was signed as completed by RN J.

7. Interviews on 2/14/24 at 9:30 a.m. and again at 4:37 p.m. with the divisional director of clinical operations I regarding the dressing change policy, procedures and education revealed she:
*Stated the following:
-There was not a dressing change policy.

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-She would use Lippincott's workbook as a professional standard reference, but there was not one on site.
-Used the LN Competency for dressing changes for staff education.
*Provided a copy of a competency titled "Licensed Nurse Competency Dressing Technique, Aseptic."

8. Review of the provider's Licensed Nurse Competency Dressing Technique, Aseptic revealed the following steps:
*"Verify order and gather needed supplies."
*"Provide privacy (closes doors, windows, curtain, etc [etcetera])."
*"Provide a clean surface, such as paper towel, to place treatment supplies in room and a plastic bag for disposal. Dressing supplies must be in sterile packages. Ointments and gels must be in original containers if they are to be placed in the open wounds."
*"Explain the procedure to be performed and provide a private environment."
*"Wash hands and apply gloves".
*"Remove soiled dressings and dispose in plastic bag with gloves."
*"Wash hands if visibly soiled or use gel hand sanitizer if not."
*"Open dressing supplies, leave in sterile packages, and place on aseptic field."
*"Apply new gloves".
*"Perform treatment as ordered."
*"Date and initial dressing according to Center procedure."
*"Remove gloves and wash hands if visibly soiled or use gel hand sanitizer."
*"Return supplies to proper area, sign TAR, document on skin grid if appropriate."

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9. Review of the provider's updated March 2018 Handwashing/Hand Hygiene policy revealed staff were to:
*Follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.
*"Hand washing with alcohol based hand rub (ABHR) is preferential to soap and water in most clinical situations."
*Use an alcohol-based hand rub or soap and water to clean their hands:
-Before and after direct contact with residents.
-Before performing any non-surgical invasive procedures.
-Before putting on sterile gloves.
-Before handling clean or soiled dressings, gauze pads, etc.
-Before moving from a contaminated body site to a clean body site during resident care.
-After contact with a resident's intact skin.
-After contact with blood or bodily fluids.
-After handling used dressings, contaminated equipment, etc.
-After removing gloves.
*"Hand hygiene is the final step after removing and disposing of personal protective equipment."
*"The use of gloves does not replace hand washing/hand hygiene."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 2/12/24 through 2/15/24. Riverview Healthcare Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy Yeaton	*Executive Director*	*3/6/2024*

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10620	A. BUILDING: _____ B. WING _____	02/15/2024

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/12/24 through 2/15/24. Riverview Healthcare Center was found not in compliance with the following requirements: S206 and S294.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on	S 206	1. Unable to correct deficient practice noted during survey. CNA E was provided with training referred to in S206 by 3/15/2024. All residents have the potential to be affected. 2. The ED educated the Human Resources Director on providing ongoing education and new hire education on said topics referenced in the 2567 by 3/7/24. Education provided in center will reference state regulation 44:73:04:05. No policy created. 3. The ED or designee will audit all new hires and 4 random employees to ensure training is completed weekly times four weeks and monthly times two months. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	3/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Timothy Yeaton | TITLE: Executive Director | (X6) DATE: 3/7/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 206	Continued From page 1 facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on review of employee personnel records and interview, the provider failed to ensure ongoing training was completed for one of one re-hired sampled employees (E) for fire prevention and response; emergency procedures and preparedness; accident prevention and safety procedures; proper restraint use; resident rights: confidentiality of resident information; incidents and disease reporting; dining assistance, nutritional risks, and hydration; and abuse, neglect, misappropriation, and mistreatment of residents. Findings include: 1. Review of employee personnel records revealed: *Certified nursing assistant (CNA) E had previously worked for the provider and his employment was terminated on 11/16/20. -He was re-hired on 5/1/22. *There were no training records, for the above-mentioned subjects, available for CNA E after he was re-hired. Interview on 2/14/23 at 2:43 p.m. with human resources D regarding employee training revealed: *CNA E was re-hired on 5/1/22. *Departmental supervisors were responsible to ensure employees complete their training. -Director of nursing (DON) B was responsible to ensure CNA E had completed his training. *She confirmed there was no documentation to support CNA E had received training in the above-mentioned subjects.	S 206		

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S 206	Continued From page 2 Interview on 2/14/24 at 12:50 p.m. with divisional director of clinical operations I revealed there was no policy for ongoing training. Interview on 2/14/24 at 2:56 p.m. with director of nursing B regarding employee training revealed CNA E had not completed his ongoing training.	S 206		
S 294	44:73:07:09 Written Menus Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, shall be written, prepared, and served as prescribed by each resident's physician, physician assistant, nurse practitioner, or qualified dietitian. Each planned menu shall be approved, signed, and dated by the dietitian for each facility. Any menu changes from month to month shall be reviewed by the dietitian and each menu shall be reviewed and approved by the dietitian at least annually if applicable. Each menu as served shall meet the nutritional needs of the residents in accordance with the physician's, physician assistant's, or nurse practitioner's orders and the Dietary Guidelines for Americans, 2010. A record of each menu as served shall be filed and retained for 30 days. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure the registered dietitian (RD) K reviewed, approved, and signed the menus annually. Findings include: 1. Review of the provider's current menus revealed they had not been approved, signed, or dated by the RD.	S 294	1. Unable to correct deficient practice noted during survey. The contract dietician signed the new US Foods menus on 2/22/24. The new menus were started on 3/3/24. 2. The ED educated the dietary manager on 3/7/2024 on ensuring menus are signed initially and annually thereafter. 3. All menus are signed for the current cycle. ED will bring to QAPI the next cycle of menus when it begins to ensure signature. Anticipated date of new cycle 9/1/2024.	3/15/2024

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S 294	Continued From page 3 Interview on 2/15/24 at 10:00 a.m. with division director of clinical operations I regarding the menus revealed the RD at that time had sent stickers to be placed as they were changing companies for their menu and they were never placed on the menu and the RD was not going to come and personally sign the menus. She agreed the menus had not been signed as having been reviewed since 9/27/22.	S 294		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/12/24 through 2/15/24. Riverview Healthcare Center was found in compliance.	S 000		