PRINTED: 03/01/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIÉS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NOWBER.	A. BUILD	A. BUILDING		С	
		435086	B. WING	B. WING			/16/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	TO TIDE! COT COO. 1 ===				611 EAST 2ND AVE		
RIVERVIE	RIVERVIEW HEALTHCARE CENTER			1	FLANDREAU, SD 57028		
(X4) ID		ATEMENT OF DEFICIENCIES	ID.	IV.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
PREFIX TAG	REFIX (EACH DEFINITION DE L'ACCEPTATION) TAG CROS		CROSS-REFERENCED TO THE APPROPRIA		DATE		
IAO					DÉFICIENCY)		-
	DETINE COMMENTS		F	000			
F 000	INITIAL COMMENTS		Г	UUU			
	A satisfaction for all	h aumou for compliance					
	A recertification near	h survey for compliance s, Subpart B, requirements			1		
	for Long Term Care fa	acilities, was conducted from					
	2/14/23 through 2/16/	23. Riverview Healthcare					
		in compliance with the					
		s: F610, F657, F686, and					
	F812.						
		rvey for compliance with 42					
CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/14/23 through 2/16/23. Areas surveyed included nursing services and accidents. Riverview Healthcare						2446422	
					1. A thorough investigation was com	1-	3/16/23
					pleted on resident 16 and reported to	0	
	Center was found in o				DOH. All residents have the potentia	II TO	
F 610		Correct Alleged Violation	F-	610	be affected. 2. The ED and DNS were educated	hv	
SS=D					the DDCO (Divisional Director of Cli	nical	
55=0	011(3). 400.12(0)(2)	(4)			Operations) on conducting a thoroug	ah in-	
	§483.12(c) In respons	se to allegations of abuse,			vestigation and the Abuse policy by	3/14/	
	neglect, exploitation,	or mistreatment, the facility			2023. No changes were needed to	the	
	must:				policy. The ED and DNS educated the	ne In-	
	\$400.40(a)(3) Have a	vidence that all alleged			terdisciplinary team by 3/16/23. All to not in attendance will be educated p	nose	
	violations are thoroug				their next working shift.	1101 10	
	Violations are thoroug	iny nivedigated.			3. The DDCO or designee will audit	all	
	§483.12(c)(3) Prevent	t further potential abuse,			reportable events monthly times six		
		or mistreatment while the			months to ensure an accurate and ti	10r-	
	investigation is in pro	gress.			ough investigation was completed.	The	
	B400 40/s\/4\ Dax = 4	the regular of all			DDCO will bring the results of these dits to the monthly QAPI committee	for	
	§483.12(c)(4) Report				further review and recommendation		
		administrator or his or her ative and to other officials in			continue or discontinue the audits.		
		e law, including to the State					
		n 5 working days of the					
		eged violation is verified					
		e action must be taken.					
	This REQUIREMENT	is not met as evidenced					
	by:		4				
		NUMBER DEDREGENTATIVEIS SIGNIATIONE	G .	_	TITLE		(X6) DATE
		SUPPLIER REPRESENTATIVE'S SIGNATURE	actor			/2023	
umoth	y Yeaton	Executive Dire	clui		3/ 9	, 2023	,

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 of notes have to correction are proved 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.

MAR 1 3 2022

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SVTB11

Facility ID: 0040

If continuation sheet Page 1 of 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/01/2023 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 435086 B. WNG 02/16/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW HEALTHCARE CENTER 611 EAST 2ND AVE FLANDREAU, SD 57028 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 610 | Continued From page 1 F 610 Based on observation, interview, record review, and policy review, the provider failed to ensure a thorough and accurately documented investigation had been conducted for one of one sampled resident (16) after a fall from her wheelchair and sustained a right femur fracture. Findings include: 1. Observation and interview on 2/15/23 at 1:45 p.m. with resident 16 revealed she had: *Slipped out of her wheelchair onto the floor. -Two staff used the full body mechanical lift to transfer her into the wheelchair before supper. -She was not positioned correctly in the wheelchair by those staff members. -Thought that the incident had occurred on 2/1/23. *She was taken taken to the emergency department (ED), evaluated, and it was determined she had broken her right knee cap *A full leg brace was placed on her right leg. Review of resident 16's medical record revealed: *She had been admitted on 12/21/22 *Her Brief Interview for Mental Status was 15 which indicated intact cognitive status. *A 2/1/23 at 6:55 p.m. interdisciplinary (IDT) nursing progress note revealed: -"Resident fell down on the floor @ [at] 17:00 [5:00 p.m.]. Stated she [is] in pain right leg/hip. Difficult to assess resident is uncooperative, given hydrocodone PRN [as needed]. Notify

[evaluation]."

E-care [emergency] with order to send to ER (emergency room] for X-ray for further eval.

-"Late entry: CNA [certified nursing assistant] reported resident on the floor. She is on the floor

*A 2/1/23 at 11:29 p.m. IDT nursing progress note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND MIDEO		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
435086			B. WING		0	2/16/2023	
	NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028			
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F 610	Continued From pa	ge 2	F 61	0			
	sitting position legs [wheelchair]." *A 2/1/23 at 10:31 prevealed: -"Resident returned ambulance @ 21:3 instructions. Pt. [paimmobilizer." *A 2/2/23 at 9:04 a. included informatio location of the fall. the fall revealed: -"Amount of assistated factor of fall." -"Environmental factor of fall." -"Environmental factor of the following initial in place to prevent proper positioning in Review of resident revealed: *She had a fracture between the wheeled: -"X-rays taken of the lower extremity were appeared to be the right knee on the supracondylar (abovas reviewed by rate of the proper position of the supracondylar (abovas reviewed by rate of the proper position of the supracondylar (abovas reviewed by rate of the proper position of the supracondylar (abovas reviewed by rate of the proper position of the supracondylar (abovas reviewed by rate of the proper position of the supracondylar (abovas reviewed by rate of the proper position of the proper positio	extended front of her w/c c.m. IDT nursing progress note d coming from ER per 0 [9:30 p.m.]. With specific titient/resident] placed in knee m. IDT fall review late entry n on the date, time, and The root cause investigation of ance an effect contributing ctors/items out of reach of fall." al interventions have been put future falls. Staff to ensure n wheel chair and recliner." 16's 2/1/23 ED discharge plan e to her right fernur. the ED provider included: at the nursing home trying to alchair slipped and then fell." the taken. The right hip shows the no acute fracture. There an abnormality associated with the distal fernur suggesting a tove the knee) fracture which diology as well." 3 at 1:02 p.m. with cation assistant (CMA) O 16's fall revealed: assually assisted into her					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED		TIPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED	
		435086	B. WING			C 02/16/2023	
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	:		
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F 610	wheelchair or recliner *Her transfer status wassistance of two staf *She had just been as *She entered the roor finished with the trans were leaving the roon *She had not noticed correctly in the wheele *She had not been int incident by administra (DON) B. Interview on 2/16/23 a regarding resident 16 *He had assisted resi with the full body lift w *He was sure that res positioned correctly in *A few minutes after the ard her yell "help." *When he went back is sitting on the floor in f *The resident stated s wheelchair. *He had not been inte incident by administra Interview on 2/16/23 a occupational therapist fall revealed: *A request had been s resident 16's wheelch *Physical therapist (P' assessment.	refuse to get into her during the day. ras to use a full body lift and f. sisted into her wheelchair. In just as CNAs N and P had sfer with resident 16 and n. if she was positioned chair. Iterviewed regarding the stor A or director of nursing at 1:07 p.m. with CNA N is fall revealed: dent 16 into her wheelchair with the assistance of CNA P, ident 16 had been in her wheelchair. The staff had left her room he sinto her room and she was ront of her wheelchair. The had slipped out of her erviewed regarding the stor A or DON B. At 1:23 p.m. with the Q regarding resident 16's seent from nursing to assess air and recliner seating. T) R had completed that serviewed regarding the erviewed regarding the greyiewed regarding th	F	610			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086		A. BUILDIN	PLE CONSTRUCTION IG	1 '	(X3) DATE SURVEY COMPLETED C 02/16/2023	
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	NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028		
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F 610	Interview on 2/16/23 a regarding resident 16 *She assisted resider wheelchair with the fu *CNA N also assisted *Resident 16 had not transfer. *She and CNA N were during the transfer of *She had not been intincident by administrational transfer of the had not been intincident by administrational transfer of the had assessed reseating earlier in the control wheelchair was approximately administrational transfer of the had not observe the had not observe the had not been intincident by administrational transfer of resident 16 falling or reviewed the incident complete investigation per the provider's policinterviews of all staff in the control of the South Elealth 2/1/23 reportated by the provider reveal *Resident 16 was not incident. *None of staff involved regarding the incident *No neglect or abuse the provider.	at 2:37 p.m. with CNA P 's fall revealed: at 16 out of bed into her all body lift. with the transfer. complained during the e the only staff in the room resident 16. terviewed regarding the at 3:04 p.m. with PT R esident 16's wheelchair day and found the size of the apriate for her. d her in that wheelchair. terviewed regarding the at 4:30 p.m. with med the incident on 2/1/23 but of her wheelchair. He report and agreed a in had not been completed cy. He would have expected involved. Dakota Department of the bid incident report submitted ed: interviewed regarding the d had been interviewed	F6	10		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILT		CONSTRUCTION	COMPLETED
		435086	B. WNG		02/16/2023
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE CENTER			6	TREET ADDRESS, CITY, STATE, ZIP CODE 111 EAST 2ND AVE CLANDREAU, SD 57028	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 610	progress notes: -"Writer was notified resident slid out of he on the floor. She was extremity. She was a Hoyer lift. Avel ecare and they stated that ER to be evaluated the was notified and agree to ER if [resident] was wanted to go to ER if transferred to the ER [4:30 p.m.]. [Resident and x-ray were taker knee. X-ray of the hibut no acute fracture an abnormality of the femur suggesting as [Resident] was place [right] leg and sent be keep knee immobilized during cares. Due to and non-weight bear was not a surgical carifall intervention: Spositioning in wheel bed." Review of the provide Abuse Investigation and is recoverseeing staff that investigations." *The provider would interviewed involved that worked to determine the state of the provider would interviewed involved that worked to determine the state of the provider would interviewed involved that worked to determine the state of the provider would interviewed involved that the provider would interviewed involved the provider would interviewed to determine the state of the provider would interviewed involved that the provider would interviewed to determine the state of the provider would interviewed involved the provider would interviewed to determine the provider would interviewe	at 1730 [5:30 p.m.] that er wheel chair and was found is in new pain in her R [right] assisted back into bed with was notified and updated if [resident] wanted to go to that would be okay. Daughter eed with the plan of sending anted to go. [Resident] for evaluation and was a via ambulance at 1630 at] was evaluated in the ER an of her R [right] hip and p showed arthritic findings at. The R [right] knee did show at R [right] knee on the distal supracondylar fracture. and in an immobilizer of the R ack to facility with orders to ther in place at all times unless [resident] morbid obesity ring status prior to injury she andidate." taff to ensure proper chair and recliner when out of ther's updated October 2023 policy revealed: ctor is the designated abuse esponsible for assigning and are to assist with have identified and	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
435086 B. WING		02/16/20					
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028			
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F 610	and would have deter cause. *The provider would hand thorough record cinvestigation. Care Plan Timing and	mined the extent and have maintained a complete of documentation of the Revision	F 610	1. Residents 12, 16, 29, and 30 have comprehensive review of their care p		2/46/22	
SS=D	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the re An explanation must be medical record if the p and their resident repr not practicable for the resident's care plan. (F) Other appropriate disciplines as determine or as requested by the (iii)Reviewed and revis team after each asses comprehensive and quassessments. This REQUIREMENT by:	days after completion of sessment. erdisciplinary team, that ited to-sician. with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). The included in a resident's participation of the resident resentative is determined development of the staff or professionals in the by the resident's needs a resident.		All resident care plans reviewed for a priate interventions. All residents har potential to be affected. 2. The DNS or designee will educate interdisciplinary team and licensed non ensuring an accurate and timely oplan is in place for all residents by 3/All those not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit for dom care plans weekly times eight who for accuracy and timeliness. The DN designee will bring the results of these dits to the monthly QAPI meeting for their review and recommendation to other review and recommendation to other review and recommendation to other the sudits.	athe urses care 16/23. lu- ur ran- reeks IS or se au- fur-	3/16/23	

STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	DENTI TOATION NUMBER.	A. BUILDIN	A. BUILDING		С	
		435086	B. WING_	B. WING		02/16/2023	
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 611 EAST 2ND AVE FLANDREAU, SD 57028	DE .			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 657	plans had been reviet they accurately reflect for 4 of 13 sampled re 30.) Findings include: 1. Observation and in p.m. with resident 16 *A compression stock *A full leg brace on he *Slipped out of her wiright knee cap. *Pain when she was side in her bed. *After she fell and frashe stayed in her bed. *A urinary catheter. *Open areas to her sident 16 *She had been admit hospital. *Her diagnoses includeft hip, right hip, and sitting bone [coccyx]) failure, obesity, and clegs. *She had a fall out of and sustained a fract Review of resident 16 revealed: *There was no focus, related to her fall from on 2/1/23. *There was a focus a for falls.	et (MDS) contractor der failed to ensure care wed and revised to ensure ted the residents care needs esidents (12, 16, 29, and deterview on 2/15/23 at 1:45 revealed she had: ding on her left leg. der right leg. deelchair and fractured her repositioned from side to retured her right knee cap deta all times. Sis medical record revealed: ted on 12/21/22 from the ded: pressure ulcers to her sacrum (area above the ded: edema, congestive heart dellulitis to right and left lower of ther wheelchair on 2/1/23 ure to her right leg.	F	957			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(A)) THOUSE CONTINUES IN THE CONTINUES I		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		435086	B. WING		02	2/16/2023	
	ROVIDER OR SUPPLIER W HEALTHCARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP COI 611 EAST 2ND AVE FLANDREAU, SD 57028	DE		
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F 657	dietary interventions integrity. *The focus, goal, an impaired skin integrity involved and interve 2. Observation and ip.m. with resident 25. *He was seated in a -Stated he slept in h -There was no bed 6. *The recliner had no reducing cushion. *His feet were not el. *He stated he had a infection on his leg. *His right lower leg r dark and red. There drainage was noted his leg. Review of resident 2 revealed: *There was a focus down with interventithaving a pressure was up in his chairHaving a pressure Interview on 2/16/23 nursing (DON) B an regarding the review resident care plans revealed: *They agreed reside updated in a timely *The provider contra	d interventions for her ty did not include all areas nitions currently in place. Interview on 2/14/23 at 4:45 arevealed: Irectiner in his room. It is recliner. In his side of the room. It pressure relieving or evated at that time. Is one on his bottom and a bad evealed his skin was very were no open areas and no. There were no dressings on 19's 1/16/23 care plan It is area related to his skin break ons that had included: Ireducing cushion when he reducing mattress on his bed. It is at 3:30 p.m. with director of d regional nurse consultant Mays and the updating of as needs and care changed ent care plans were not manner. In acted with a company who he assistant director of	F 6	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		435086 B. WING				С	
1	PROVIDER OR SUPPLIER EW HEALTHCARE CENT			STREET ADDRESS, CITY, STATE, ZIP COD 611 EAST 2ND AVE FLANDREAU, SD 57028)E	02/16/2023	
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	ensure resident care current care needs. 3. Observation and in p.m. with resident 30 *Was sitting in a reclir elevated. *Had a Prevalon boot Review of resident 30 *He had been admitte *His 12/20/22 brief int (BIMS) score was 15, intact. *His diagnosis include hemiparesis following left non-dominant side fibrillation, chronic pair diabetes, and disorder subcutaneous tissue. *He had an unstageab heel from 3/9/22 throug *On 12/17/23 he was founstageable pressure ulcer water and intervention in his case Refer to F686, finding 14. Review of resident 12 revealed: *He had been admitted	nave an actual process to plans reflected the residents terview on 2/14/23 at 4:30 revealed he: her in his room with his feet placed on his left foot. 's medical record revealed: don 4/24/20. erview for mental status indicating his cognition was defended: don 4/24/20. erview for mental status indicating his cognition was defended infarction affecting heart failure, atrial a syndrome, type II of the skin and defended in the skin and defended in the skin and defended in the skin and series are plan. 2. 11/10/22 care plan boot was not included as are plan. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2	Fe				
(ognition was severely i	re was 6, indicating his impaired. to hospice care on 2/1/23.					

NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE CENTER CALID C	STATEMENT OF DEFICIENCIES (0 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	COMPLETED			
RIVERVIEW HEALTHCARE CENTER SLIMARY STATEMENT OF DEPOLENCES (EACH DEPOLENCY AUST SEPRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) F 657 Continued From page 10 "He was found to have a blister on his right heel on 1/24/23 for dressings to the right fool. "On 2/14/23 he was found to have wo open areas on his right butlocks. "On 2/15/23 he was found to have a stage II pressure ulcer to his butlocks. "An ew wheelchair cushion was implemented and an air mattress was requested from hospice. Review of resident 12's 2/14/23 care plan revealed: "No new intervention had been implemented for skin issues since 11/21/22. "The agg crate boot out and heel lift pillow were not included in his care plan. Refer to F686, finding 2. Review of the provider's October 2022 Skin Integrity policy revealed when a resident developed a skin impairment interventions should have been implemented and documented on the care plan. On 2/16/23 at 3:10 p.m. a care plan policy had been requested from regional nurse consultant M and she had indicated the provider did not have a policy.	435986 B. WNG				I				
PREFIX TAG CONTINUED TO PRECIDENCY AUGST BE PRECEDED BY FULL REGULATORY OR LISC IDEMTIFYING INFORMATION) F 657 Continued From page 10 "He was found to have a blister on his right heel on 1/24/23. "A physician's order had been received on 1/24/23 for dressings to the right heel and to use an egg crate boot to the right foot. "On 2/14/23 he was found to have a stage II pressure ulcer to his buttocks. "The nurses note did not specify where it was on his buttocks. "A new wheelchair cushion was implemented and an air mattress was requested from hospice. Review of resident 12's 2/14/23 care plan revealed: "No new intervention had been implemented for skin issues since 11/21/22. "The egg crate boot and heel lift pillow were not included in his care plan. Refer to F686, finding 2. Review of the provider's October 2022 Skin Integrity policy revealed when a resident developed a skin impairment interventions should have been implemented and documented on the care plan. On 2/16/23 at 3:10 p.m. a care plan policy had been requested from regional nurse consultant M and she had indicated the provider did not have a policy.			R		611 EAST 2ND AVE				
"He was found to have a blister on his right heel on 1/24/23. *A physician's order had been received on 1/24/23 for dressings to the right heel and to use an egg crate boot to the right foot. *On 2/14/23 he was found to have two open areas on his right buttocks. *On 2/15/23 he was found to have a stage II pressure ulcer to his buttocks. -The nurses note did not specify where it was on his buttocks. -A new wheelchair cushion was implemented and an air mattress was requested from hospice. Review of resident 12's 2/14/23 care plan revealed: *No new intervention had been implemented for skin issues since 11/21/22. *The egg crate boot and heel lift pillow were not included in his care plan. Refer to F686, finding 2. Review of the provider's October 2022 Skin Integrity policy revealed when a resident developed a skin impairment interventions should have been implemented and documented on the care plan. On 2/16/23 at 3:10 p.m. a care plan policy had been requested from regional nurse consultant M and she had indicated the provider did not have a policy.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ULD BE COMPLETION			
Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686	*He was found to hav on 1/24/23. *A physician's order in 1/24/23 for dressings an egg crate boot to t *On 2/14/23 he was for areas on his right butt *On 2/15/23 he was for pressure ulcer to his buttocks. -A new wheelchair curan air mattress was received of resident 12 revealed: *No new intervention skin issues since 11/2 *The egg crate boot a included in his care plan. Review of the provide Integrity policy revealed eveloped a skin impart have been implement care plan. On 2/16/23 at 3:10 p. 1 been requested from and she had indicated policy. Treatment/Svcs to Pre CFR(s): 483.25(b)(1)(e a blister on his right heel ad been received on to the right heel and to use he right foot. bund to have two open ocks. bund to have a stage II buttocks. hot specify where it was on shion was implemented and equested from hospice. 's 2/14/23 care plan had been implemented for 1/22. nd heel lift pillow were not an. 2. 's October 2022 Skin ed when a resident airment interventions should ed and documented on the m. a care plan policy had regional nurse consultant M I the provider did not have a event/Heal Pressure Ulcer i)(ii)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. Boilbin		l c		
		435086	B. WING		1	16/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
DIVEDVIE	W HEALTHCADE CENTE	:D		611 EAST 2ND AVE			
KIVEKVIE	RIVERVIEW HEALTHCARE CENTER			FLANDREAU, SD 57028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE	
F 686	Based on the compre resident, the facility m (i) A resident receives professional standard pressure ulcers and dulcers unless the individemonstrates that the (ii) A resident with prenecessary treatment a with professional stan promote healing, prevnew ulcers from deve This REQUIREMENT by: Based on observation and policy review, the two of four sampled rewere at risk of skin brownersure ulcers from a "Care plans updated to interventions to preventing include: 1. Observation on 2/1/resident 30 revealed h "Was sleeping in a rediet elevated. *Had a Prevalon boot the heel to reduce prepropping his heel off the Review of resident 30 "He had been admittee "His 12/20/22 Brief Int (BIMS) score was 15, intact. *His diagnosis include	hensive assessment of a nust ensure that- care, consistent with sof practice, to prevent ones not develop pressure vidual's clinical condition by were unavoidable; and services, consistent dards of practice, to tent infection and prevent doping. is not met as evidenced in, interview, record review, provider failed to ensure esidents (12 and 30) who eakdown had: es implemented to prevent developing. oreflect the current ent skin breakdown. 4/23 at 10:58 a.m. of the: cliner in his room with his (cushioned boot that floats ssure) under his left ankle the footrest of the chair. Is medical record revealed: d on 4/24/20. erview for Mental Status indicating his cognition was	F 68	1. A comprehensive review of reside and 30 care plan was completed by 23 to ensure appropriate intervention in place. All residents at risk were reviewed and appropriate intervention in place. All residents have the pote to be affected. 2. The ED, DNS and interdisciplinar reviewed the skin policy by 3/13/23 changes were needed in the policy. DNS or designee educated all nursi staff on their role and responsibility prevention of pressure ulcers as we their responsibility in identifying and menting, documenting and care plan preventative measures and approact 3/16/23. All staff not in attendance and educated prior to their next working. 3. The DNS or designee will audit 4 dom residents at risk for skin breaked to ensure appropriate interventions place and documented to prevent place and documented to place and document	ay team No The ng in the ll as imple- nning ches by will be shift. l ran- down are in res- and S or ise au- r fur-	3/16/23	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		435086	B. WING	B MAING		C 02/16/2023	
	DOVIDED OR SUDDI IED	435000	B: Willo	STREET ADDRESS, CITY, STATE, ZIP CODE		JE 10/2025	
	NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE CENTER			611 EAST 2ND AVE FLANDREAU, SD 57028			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 686	moderate risk. *He had an unstagea heel from 3/9/22 throughout the pressure ulcate to his left foot at the prevalent series and pressure ulcate the was at risk for sk. *He was at risk for sk. *He was at risk for sk. *He had a pressure ulcate the was at risk for sk. *He had a pressure ulcate the was at risk for sk. *He had a pressure ulcate the was at risk for sk. *He had a pressure ulcate the was at risk for sk. *He had a pressure ulcate the was at risk for sk. *He had a pressure ulcate the was at risk for sk. *He was at risk for sk. *He had a pressure ulcate the was at risk for sk. *He had a pressure ulcate the was at risk for sk. *He was at risk for sk.	e, heart failure, atrial in syndrome, type II er of the skin and a Scale for predicting fore showed he was at ble pressure ulcer to his left fugh 3/30/22. In shad been documented er had developed. If ound to have re-developed sure ulcer to his left heel. In shad been documented er had re-developed. It is healed on 1/9/23. It is needed. It is needed. It is not documented in the cord. It is 11/10/22 care plan In breakdown. It is on his left heel from It is try skin to remain intact ate." It is it is to wound healing - In and depth where possible. In status of wound perimeter, Ing progress. Report eclines to the MD [medical line to apply lotion to dry skin." les/protocols for the	F 6	86			

			3) DATE SURVEY COMPLETED			
		435086	B. WING			02/16/2023
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER		STREET ADDRESS, CITY, STATE, 2 611 EAST 2ND AVE FLANDREAU, SD 57028	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE
F 686	-"Use bilateral assist assist with turning/repcue me to use." *No new interventions since 6/17/22. *The Prevalon boot winterventions. Interview on 2/16/23 nursing (DON) B regaling and the had COVID-19 in his health had decline the had been hospital facility on 12/15/22. *He had not worn the the hospital because the had not know whimplemented, but had he returned from the the returned from the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not docume pressure ulcer to his the there was not document to his the his	g cushion in my wheelchair." bars with encouragement to positioning in bed. Please s had been implemented ras not included in the at 4:30 p.m. with director of arding resident 30 revealed: a early December 2022 and ad. Alized and returned to the AFO since he returned from the was not walking. Then the Prevalon boot was at stated it was not until after thospital. It was completed on turned from the hospital and tentation that indicated a telf heel. If have included the Prevalon thould have reflected the place after he had the ulcer. 4/23 at 2:45 p.m. of resident the had a heel lift pillow (used the heels) on the foot of his	F	386		

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		435086	B. WING		02	/16/2023
	ROVIDER OR SUPPLIER W HEALTHCARE CENTI	ER		STREET ADDRESS, CITY, STATE, ZIP CO 611 EAST 2ND AVE FLANDREAU, SD 57028	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 686	*He had been admitted *His 12/19/22 BIMS is cognition was severed *He had been admitted *He was found to have on 1/24/23. *A physician's order in 1/24/23 for dressings an egg crate boot to the *The certified nurse in 1/24/23 revealed he had his right heel and she caused from friction. *On 2/14/23 he was four areas on his right but *On 2/15/23 he was for pressure ulcer to his -The 2/15/23 nurses was located on his body and air mattress was in Review of resident 12 from 1/30/23 through *He had a blister on his a pressure ulcer or call the had a pressure ulcer or call the had a pressure ulcer or call the had a wound on assess and treat. *She stated she would the wound when she treatment.	2's medical record revealed: ed on 8/9/22. Ecore was 6 indicating his ly impaired. ed to hospice care on 2/1/23. er a blister on his right heel mad been received on to the right heel and to use the right foot. Fractitioner's note from had a blister to the back of had questioned if it was found to have two open tocks. Found to have a stage II buttock. Fractioner's note from hot of the had questioned if it was found to have mote and equested from hospice. E's weekly skin evaluations 2/13/23 revealed: his right heel. e blister to his right heel was aused from friction. at 8:59 a.m. with registered	F	386		

		A. BUILDIN	NG		COMPLETED
	435086	B. WING			C 02/16/2023
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 611 EAST 2ND AVE FLANDREAU, SD 57028	ODE	52 10/2020
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCE	ION SHOULD BE HE APPROPRIA	
F 686 Continued From page 15 had done the treatment. Review of resident 12's care *He was at risk for skin brea *He had a wound on his righ on his buttock. *The goal was "I want to be through the review date." *The interventions included: -"Avoid scratching and keep parts from excessive moistu short." -"Educate resident/family/ca factors and measures to pre -"Follow facility protocols for -"Identify/document potential and eliminate/resolve where -"Keep skin clean and dry. U -"The resident needs pressu on bed to protect the skin wh -"Weekly treatment documen measurement of each area of width, length, depth, type of and any other notable chang -"Pressure reducing cushion *No new intervention had be since 11/21/22. *The egg crate boot had not care plan. *The heel lift pillow was not i plan. 3. Review of the provider's C Integrity policy revealed: *"The nurse establishes a Pla based on risk factors in an ei potential effects." *When a resident developed interventions should have be	kdown. It heel and open area free of skin injuries hands and body re. Keep fingernails regivers of causative vent skin injury." treatment of injury." I causative factors possible." Ise lotion on dry skin." re reducing mattress hile IN BED." htation to include of skin breakdown's tissue and exudate les or observations." in wheelchair." en implemented been included in the ncluded in the care october 2022 Skin an of Care (POC) ffort to limit their a skin impairment,	F 6	86		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLE	
		435086	B. WING		C 02/16/2023
.,	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 686 F 812 SS=F	CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety The facility must - §483.60(i)(1) - Procura approved or considere state or local authorition (i) This may include for from local producers, and local laws or regulation (ii) This provision does facilities from using prepardens, subject to considere safe growing and food (iii) This provision does from consuming foods §483.60(i)(2) - Store, serve food in accordants standards for food ser This REQUIREMENT by: Based on observation provider failed to ensue environment had been main kitchen and two provided food service facility. Findings include: 1. Observation and inte p.m. with dietary mana- tour revealed:	are plan. ore/Prepare/Serve-Sanitary y requirements. e food from sources ed satisfactory by federal, es. od items obtained directly subject to applicable State dations. s not prohibit or prevent roduce grown in facility impliance with applicable d-handling practices. s not preclude residents on to procured by the facility. prepare, distribute and noce with professional vice safety. is not met as evidenced n, and interview, the ure a clean and sanitary n maintained for one of one of two kitchenettes that to all 49 residents in the	F 68	2 1. A cover has been placed on mixe electrical panel has been sanded an painted, window screen has been chand AC units properly sealed by 3/14 A contractor has submitted a bid to ceiling and replace cupboards prior 2023. All residents have the potential affected. 2. The ED or designee has educated maintenance and dietary manager of deficient practice and maintaining a and sanitary kitchen by 3/16/23. 3. The ED or designee will audit the kitchen monthly times six months to sure a safe sanitary environment. Tor designee will bring the results of the audits to the monthly QAPI committed further review and recommendation continue or discontinue the audits.	d eaned 6/23. repair to 6/1/ al to be d n the safe en- he ED hese ee for
		-	*		

PRINTED: 03/01/2023 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRU- AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
			155.25				С
		435086	B. WING			02	/16/2023
NAME OF F	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		
				611 EA	AST 2ND AVE		
RIVERVIE	W HEALTHCARE CENT	ER		FLAN	DREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	because baked good prepared there. *There had been a sand cupboards used supplies. *The ceiling above to damage. -The paint was crace the ceiling surface. -There was a round circumference where and had fallen out. *An ice machine had baking room on the which caused the was the water damage date. *An electrical box ne bottom third of the baurface. Observation on 2/14 dishroom area reveal the damaged ceiling above the disarea. *The designated cle of the damaged ceiling above the disarea. *There were clean, uracks stacked and surface. Observation on 2/14 kitchen revealed: *A screened-in wind dietary staff due to the damaged ceit of the damaged ceiling above the disareal.	lled it "the baking room" ds had been mixed and small prepping counter area it for storage of baking he room had significant water ked, peeling and flaking off of hole about 6 inches in the the dry wall was exposed di been located above the second floor and had leaked atter damage. The had happened prior her start ext to the elevator with the floor rusted and an uncleanable shwasher, and dish work an area was within a few feet ing. Uncovered glasses in the dish tored there. 1/23 at 3:11 p.m. of the main ow had been opened by he heat in that area. w's screen had fuzz, dust, and	F	312			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
	*:	435086	B. WING			02/16/2023	
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR. (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 812	where food was preparative window air conceptaced with a wooder area. -The AC units were noutdoor elementsThe vents to both of with a dark and fuzzy-Cobwebs with dark cunits. *The ceiling above the cracked, flaked, and parative were exposed to the wire of the wire	ared. ditioner (AC) units had been a surround above the window of well sealed from the the AC units were covered debris. debris surrounded both AC as food preparation area had beeling paint. electrical wires that were indow frame. 23 at 3:18 p.m. of the two if floor revealed: under both kitchenette inde board that was water and crumbling. In not cleanable surfaces. at 10:31 a.m. with dietary is above observations were indowed and indouble have been moved to preparation and covered in box should have been dies current condition. In not have been used to its current condition. Dened the kitchen windows	F8	12			

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(X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
, , , , , , , , , , , , , , , , , , , ,			A. BUILDI	A. BUILDING		,	c l
		435086	B. WNG				16/2023
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER		611 EAS	ADDRESS, CITY, STATE, ZIP CODE T 2ND AVE REAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 812	-Window screens sho opened to cool the kit -The cobwebs around overlooked and shoul -Any areas with bad prepaired and repainte -All of the areas woul possible contamination for the residentsShe had just started maintenance schedul staff to follow. Interview on 2/16/23 administrator A revea *He was in agreement needed to have been above observations. *The water damage to dishroom from the ice four or five or weeks at the agreed those are soon as possible. *The AC units should from dirt, cobwebs, at *The water damaged kitchenette sinks should treated to the should should the	build have been clean if techen. If the AC units had been led have been removed, paint should have been red. If the AC units had been led have been concern for on of foods being prepared making a new cleaning and le/checklist for the dietary led: It there was repair work that completed regarding the led the kitchen areas and le machine had happened lago. It has should been fixed as have been sealed and free	F	312			

PRINTED: 03/01/2023

FORM	APPROVED
OMR NO	0938-0391

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		MPLETED
		105000	B. WING			2/16/2023
	ROVIDER OR SUPPLIER	435086 ER	B. WING	STREET ADDRESS, CITY, STATE, ZII 611 EAST 2ND AVE FLANDREAU, SD 57028		
(X4) ID PREFIX TAG	(FACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		and the second s
	CFR Part 482, Subp Emergency Prepare Term Care facilities	vey for compliance with 42 wart B, Subsection 483.73, dness, requirements for Long was conducted from 2/14/23 verview Healthcare Center ance.				
				TITLE		(X6) DATE
		R/SUPPLIER REPRESENTATIVE'S SIGNAT	^{ture} tive Dire		3/9/.	2023
ny deficienc ther safegua	ards provide sufficient prote date of survey whether or g the date these document	n asterisk (*) denotes a deficiency which ection to the patents (Self) istruction is not uplan of consected is provided. For a remade available to the facility.	the institution ma	ay be excused from correcting providing homes, the findings stated above the above findings and plans of corrections.	ing it is determined that are disclosable 90 days ction are disclosable 14	
ORM CMS-25	567(02-99) Previous Versions (MAR 1 0 2022 Event D.S	SVT 111	Facility ID: 0040	If continuation	on sheet Page 1 of

PRINTED: 03/01/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUC NG 01 - MAIN BI		(X3) DATE COMP	SURVEY LETED
		435086	B. WNG			02/	14/2023
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	:R		611 EAST 2N	RESS, CITY, STATE, ZIP CODE ND AVE AU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		Κ¢	000			
K 223 SS=E	Life Safety Code (LSC occupancy) was cond Healthcare Center was with 42 CFR 483.90 (Term Care Facilities. The building will mee: 2012 LSC for existing upon correction of de K271, K353, K355, K with the provider's co-compliance with the f Doors with Self-Closin CFR(s): NFPA 101 Doors with Self-Closin CFR(s): NFPA 101 Doors with Self-Closin CFR(s): NFPA 101 The building will mee: 2012 LSC for existing upon correction of de K271, K353, K355, K with the provider's compliance with the f Doors with Self-Closin CFR(s): NFPA 101 Doors with Self-Closin CFR(s): NFPA 101 Doors with Self-Closin CFR(s): NFPA 101 The building will mee: 2012 LSC for existing the following with	ng Devices ageway, stairway enclosure, oke barrier, or hazardous elf-closing and kept in the sis held open by a release in 7.2.1.8.2 that automatically throughout the smoke elfacility upon activation of: elarm system; and ors designed to detect gh the opening or a required em; and system, if installed; and in 19.2.2.2.7, 19.2.2.2.8 is not met as evidenced in and interview, the provider	K2	1. 2.	All residents have the pital to be affected All exit passageways, steenclosures, smoke barriers, hazardous area enclosures been equipped with automore closures by 3/10/2023. EDecated Maintenance on requirement for doors with self-clodevices by 3/10/2023. The ED or designee will all doors monthly times six months to ensure all exit paways, stair enclosures, horizexits, smoke barriers, or harardous areas have functions sures that automatically closuch doors. The ED or designed will bring the results of these dits to the monthly QAPI content for further review and remendation to continue or ditinue the audits.	airway and have atic edu- ire- sing audit assage- contal z- al clo- se all nee se au- mmit- ecom-	3/16/23
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Timothy Yeaton

Executive Director

3/9/2023

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 quising homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made suitable to the facility. It deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Vers

MAR 1 0 2022

Facility ID: 0040

If continuation sheet Page 1 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X3) DATE SURVEY COMPLETED	
	435086	B. WING		02/14/2023
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE CENTER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
room 13 being used as the front entry, and lau Findings include: 1. Observation on 2/14 the north stairwell doo a closer installed on the 2. Observation on 2/14 resident room 9 was bover one hundred squacloser installed on the 3. Observation on 2/14 resident room 11 was over one hundred squacloser installed on the 4. Observation on 2/14 resident room 13 was over one hundred squacloser installed on the 5. Observation on 2/14 the clothing room, use items, was over one horthave a closer instarequired by code. 6. Observation on 2/14 the laundry room was feet and considered has a latching door as required by code as required with the maintime of the observation	g used as storage, resident a storage, clothing room at indry room) as required. 1/23 at 10:15 a.m. revealed or on first floor no longer had be door as required by code. 1/23 at 10:25 a.m. revealed eing used as storage, was are feet, and did not have a door as required by code. 1/23 at 10:30 a.m. revealed being used as storage, was are feet, and did not have a door as required by code. 1/23 at 10:35 a.m. revealed being used as storage, was are feet, and did not have a door as required by code. 1/23 at 11:10 a.m. revealed being used as storage, was are feet, and did not have a door as required by code. 1/23 at 11:10 a.m. revealed did for storage of charitable undred square feet, and did alled on the door as	K 22	23	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY LETED
		435086	B. WING		02/	14/2023
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 271	where they were local	e smoke compartment	K 22		oten-	3/16/23
	provides a level walking provisions of 7.1.7 with elevation and shall be obstructions. Addition be a hard packed all-value and the structions of the structions. Addition be a hard packed all-value and the structure of the struc	ally, the exit discharge shall weather travel surface. is not met as evidenced n, testing, and interview, the ide a clear egress public way. One of seven west wing, second level) ow. Findings include: 4/23 at 1:45 p.m. revealed in the west resident wing cleared of snow to the grevealed approximately 15 in the egress path. Interview supervisor at the time of the		 All outdoor exits have be cleared of snow by 3/10/20 educated Maintenance on eing all outdoor exits provided clear egress discharge path 10/2023. The ED or designee with all outdoor exits weekly for mainder of 2023 snow season The ED or designee will bring results of these audits to the monthly QAPI committee for their review and recommend to continue or discontinue the dits. 	23. ED ensur- e a by 3/ n audit re- on. g the e or fur- dation	
K 353 SS=E	the smoke compartme Sprinkler System - Ma CFR(s): NFPA 101 Sprinkler System - Ma Automatic sprinkler ar	aintenance and Testing aintenance and Testing and standpipe systems are I maintained in accordance	K 35	See next page	í	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		435086	B. WING		02/	14/2023	
RIVERVIE	ROVIDER OR SUPPLIER W HEALTHCARE CEN	ITER STATEMENT OF DEFICIENCIES	61	REET ADDRESS, CITY, STATE, ZIP CODE 1 EAST 2ND AVE ANDREAU, SD 57028 PROVIDER'S PLAN OF CORR	ECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLÉTION DATE	
K 353	Testing, and Mainte Protection Systems maintenance, inspormantained in a sea available. a) Date sprinkler in the provided in REMAR any non-required consistent. 9.7.5, 9.7.7, 9.7.8, This REQUIREME by: Based on observation on standpipe tags on available for the arrequired quarter performed in the planterview with main of the record review on the required any quarter performed any quarter perfo	aining of Water-based Fire is. Records of system design, ection and testing are cure location and readily system last checked system test supply source. EKS information on coverage for or partial automatic sprinkler and NFPA 25 NT is not met as evidenced attion, record review and ider failed to continuously caprinklers in reliable operating of flow test not done during the is). Findings include: 2/14/23 at 11:30 a.m. showed the sprinkler system were only included the system. 2/14/23 at 2:30 p.m. revealed enly flow tests had not been ast year by the contractor. Intenance supervisor at the time we confirmed he had not arterly flow tests. Insuly maintain the automatic is required increases the risk of	K 353	 All residents hav tial to be affected. The sprinkler sys pany will train maint rector on quarterly f by 4/1/2023. The ED the maintenance din importance of quartesting by 3/10/2023. The ED or design quarterly times two the flow testing has pleted and training of ing has occurred. The signee will bring the these audits to the meeting for further recommendation to discontinue the audit 	tem com- enance di- low testing educated ector on the erly flow 3. hee will audit quarters that been com- on flow test- e ED or de- results of nonthly QAPI review and continue or	3/16/23	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		435086	B. WING		02/14/2023	
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
K 353 K 355 SS=D	tests on the automatic Portable Fire Extingui CFR(s): NFPA 101 Portable Fire Extingui Portable fire extinguis inspected, and mainta NFPA 10, Standard for Extinguishers. 18.3.5.12, 19.3.5.12, This REQUIREMENT by: Based on observation failed to properly main first floor resident livin wings of first floor). 1. Observation and in beginning at 10:15 a.r. a.m. revealed all extin west wings of first floor 2023 inspection. Interview with the enviat the time of the observation. He was not aware monthly check. The deficiency has the smoke compartments Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the finding and simulation conditions. Fire drills are string and simulation conditions. Fire drills are string and simulation conditions.	sprinkler system. shers shers hers are selected, installed, ined in accordance with r Portable Fire NFPA 10 is not met as evidenced and interview, the provider stain fire extinguishers in the grarea (north and west) serview on 2/14/23 and extending until 11:30 guishers in the north and revere missing the January, ironmental services director extration confirmed that ware how to perform the expotential to affect both	K3	 All residents have the potial to be affected. All fire exguishers have been inspected prior to 3/10/2023. The ED educated maintenance director on the importor of monthly fire extinguisher spections and maintenance 10/2023. The ED or designee will all fire extinguishers monthly times four months for timely spection and maintenance. ED or designee will bring the sults of these audits to the monthly QAPI committee for ther review and recommend to continue or discontinue the dits. 	etin- ed e- tance in- by 3/ audit y y in- The e re- fur- dation	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED
		435086	B. WING		02/14/2023
	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION				
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
K 712	with procedures and in established routine. It between 9:00 PM and announcement may be alarms. 19.7.1.4 through 19.7 This REQUIREMENT by: Based on record reviporovider failed to: *Maintain documentally year. *Hold fire drills at vary year. *Document transmission during the drills. *Ensure staff were fall procedures. Findings include: 1. Record review on 2.	th shift. The staff is familiar is aware that drills are part of Where drills are conducted in 6:00 AM, a coded in the used instead of audible in 1.7. The is not met as evidenced it is not met as evidenced it is not fire drills for the past it is not the fire alarm signal imiliar with fire drill	K 71	 All residents have the tial to be affected. Deficies practice to be corrected material forward. Education provided to tenance supervisor by 3/1 on timely practice of fire of the duct a monthly audit for 1 months to ensure adequare number of fire drills compound The ED or designee will be results of these audits to the monthly QAPI committee ther review and recommetion to continue or discontinue audits. 	main- 0/2023 Irills. Ill con- 2 te leted. ing the the for fur- enda-
K 918 SS=E	the record reviews co stated there had been no documentation of he stated he knew th The deficiency had the the building occupant Electrical Systems - I CFR(s): NFPA 101 Electrical Systems - I Maintenance and Tes	ne potential to affect 100% of its. Essential Electric Syste Essential Electric System	K 9	See next page	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY PLETED
		435086	B. WING		02	/14/2023
RIVERVIE	NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF SUPPLIES OF THE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF SUPPLIES OF THE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF THE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF THE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF THE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF THE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF THE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF THE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF THE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF THE PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF THE PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF THE PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF THE PREFIX (EACH CORRECTIVE ACTION SHOULD ID OF THE PROVIDER OF THE PREFIX ID OF THE PREFIX ID OF THE PROVIDER OF THE PREFIX		RRECTION	(X5) COMPLETION		
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	CROSS-REFERENCED TO THE	APPROPRIATE	DATE
K 918	service within 10 seccoriterion is not met du process shall be provicapability for the life significant with NFPA 110. Generator sets are insunder load 30 minutes day intervals, and exemonths for 4 continuounder load conditions simulated cold start at transfer of all EES load competent personnel, stored energy powers accordance with NFPA circuit breakers are in program for periodical components is establication manufacturer requirer maintenance and test readily available. EES circuits are marked, reseparate from normal the possibility of dama source is a design coninstallations. 6.4.4, 6.5.4, 6.6.4 (NF 111, 700.10 (NFPA 70	ment is capable of supplying ands. If the 10-second ring the monthly test, a ded to annually confirm this afety and critical branches. Ing of the generator and performed in accordance spected weekly, exercised a 12 times a year in 20-40 roised once every 36 us hours. Scheduled test include a complete and automatic or manual ds, and are conducted by Maintenance and testing of sources (Type 3 EES) are in A 111. Main and feeder spected annually, and a ly exercising the shed according to ments. Written records of a remaintained and electrical panels and power circuits. Minimizing age of the emergency power asideration for new PA 99), NFPA 110, NFPA The provided in the record of the emergency power asideration for new PA 99), NFPA 110, NFPA The provided in the record of the emergency power asideration for new PA 99, NFPA 110, NFPA The provided in the record of the emergency power asideration for new PA 99, NFPA 110, NFPA The provided in the record of the emergency power asideration for new PA 99, NFPA 110, NFPA The provided in the record of the emergency power asideration for new PA 99, NFPA 110, NFPA The provided in the record of the emergency power asideration for new PA 99, NFPA 110, NFPA The provided in the record of the emergency power asideration for new PA 99, NFPA 110, NFPA The provided in the record of the emergency power asideration for new	K	1. All residents have tial to be affected. Detice to be corrected ward. 2. Education provision on the need for come documenting weekly monthly generator on maintaining a part erator. 3. The ED or design weekly times six we monthly times three ensure generator mecompleted and documentary that a path is maintagenerator. The ED of will bring the results dits to the monthly tee for further review mendation to continue the audits.	ded to main- by 3/10/2023 apleting and y and maintenance. ided to main- by 3/10/2023 th to the gen- nee will audit eks and e months to aintenance is amented and ained to the r designee s of these au- QAPI commit- w and recom-	3/16/23

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		SURVEY LETED
		435086	B. WING		02/	14/2023
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 918	monthly maintenance calendar year 2022 at 2. Record review on revealed there was not weekly maintenance calendar year 2022 at path through the snot Interview with the material 2/14/23 at 3:00 p.m. under load each mor Since this loaded test manufacturer he belief requirements.	o documentation of the e for the generator for and 2023. 2/14/23 at 2:35 p.m. o documentation of the for the generator for and 2023. There was also now to the generator. Sintenance supervisor on revealed the generator ran atth on the seventh at 10 a.m.	K 9	18		

PRINTED: 03/01/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1989 ADDITION				SURVEY PLETED
		435086	B. WNG			02/	14/2023
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER.		STREET ADDRE 611 EAST 2ND FLANDREAU			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BI OSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000		ey for compliance with the	K 000				
	occupancy) was cond Healthcare Center wa	C) (2012 existing health care lucted on 2/14/23. Riverview as found not in compliance a) requirements for Long					
	2012 LSC for existing upon correction of de K712 and K918 in cor	the requirements of the health care occupancies ficiencies identified at K353, and a high representation with the provider's used compliance with the fire	-				
K 353 SS=E		aintenance and Testing	K 353	1.	All residents have the po al to be affected.	oten-	3/16/23
	Automatic sprinkler are inspected, tested, and with NFPA 25, Standa Testing, and Maintain Protection Systems. Finantenance, inspect	e location and readily		q 20 te	The sprinkler system convill train maintenance direct uarterly flow testing by 4/1023. The ED educated the renance director on the impance of quarterly flow testin/10/2023.	tor on ./ main- or-	
	b) Who provided sys	tem test			The ED or designee will a uarterly times two quarter	s that	
	c) Water system sup	ply source			he flow testing has been co		
	any non-required or p system. 9.7.5, 9.7.7, 9.7.8, an	information on coverage for artial automatic sprinkler d NFPA 25 is not met as evidenced		h w d	leted and training on flow to as occurred. The ED or des will bring the results of these its to the monthly QAPI me for further review and recor ation to continue or discon	ignee e au- eeting nmen-	
		NIDDI IED DEDDESENTATIVE'S SIGNATI ID			ation to continue or discon		(X6) DATE

Timothy Yeaton

Executive Director

3/9/2023

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 ruided a pellatin to the day following the date these documents are ruided a pellatin to the day of the d program participation.

MAR 1 0 2022 vent ID

SD DOH-OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Facility ID: 0040

the audits.

If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1989 ADDITION			(X3) DATE SURVEY COMPLETED	
		435086	B. WING		02/14/2023	
		TATEMENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028 ID PROVIDERS PLAN OF COR		RECTION (X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DATE	
K 712	interview, the provide maintain automatics condition (quarterly past twelve months). 1. Observation on 2/ standpipe tags on the available for the annual Record review on 2/ the required quarterly performed in the past Interview with mainter of the record review performed any quarterly formed formed formed for the signal and simulation conditions. Fire drills fire drills include the signal and simulation conditions. Fire drills unexpected times unleast quarterly on easiest quarterly on easiest performed for the signal and simulation conditions. Fire drills unexpected times unleast quarterly on easiest quarterly on easiest performed for the signal and simulation conditions. Fire drills unexpected times unleast quarterly on easiest performed for the formed formed for the signal and simulation conditions. Fire drills unexpected times unleast quarterly on easiest performed for the formed formed formed for the formed formed for the formed formed formed formed for the formed formed formed for the formed for the formed fo	on, record review and per failed to continuously prinklers in reliable operating flow test not done during the Findings include: 14/23 at 11:30 a.m. showed the sprinkler system were only usal testing of the system. 14/23 at 2:30 p.m. revealed by flow tests had not been stry are by the contractor. The supervisor at the time confirmed he had not terly flow tests. Is y maintain the automatic required increases the risk of the fire. It do no of numerous required the sprinkler system. It is aware that drills are part of the word of the side of the street o	K 35	 All residents have the tial to be affected. Defice to be corrected move ward. Education provided tenance supervisor by 3 	to main- //10/2023 e drills. will con- r 12 uate num- ted. The g the re- the ee for fur- mendation	

	DF DEFICIENCIES CORRECTIÓN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 02 - 1989 ADDITION	COMPLETED
		435086	B. WING_		02/14/2023
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
K 712 K 918 SS=E	by: Based on record rev provider failed to: *Maintain documental year. *Hold fire drills at vary year. *Document transmiss during the drills. *Ensure staff were far procedures. Findings include: 1. Record review on 2 revealed there were re 2. Interview with the at the record reviews co stated there had been he would not produce drills and stated he kn The deficiency had th the building occupant Electrical Systems - E CFR(s): NFPA 101 Electrical Systems - E Maintenance and Tes The generator or othe and associated equip service within 10 secce criterion is not met du process shall be prov capability for the life s Maintenance and test	iew and interview, the tion of fire drills for the past ving times during the past ion of the fire alarm signal miliar with fire drill 2/14/23 at 2:30 p.m. to records for fire drills. Indiministrator at the time of infirmed those findings. He in drills conducted. However any documentation of the new that was a problem. It is not met as evidenced. However any documentation of the new that was a problem. It is not met as evidenced. However any documentation of the new that was a problem. It is not met as evidenced.	K 7		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1989 ADDITION		(X3) DATE SURVEY COMPLETED		
		435086	B. WING_			02/	14/2023
		ATEMENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		-	(X5) COMPLETION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	· c	(EACH CORRECTIVE ACTION SHOULD E PROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE
K 918	under load 30 minute day intervals, and exe months for 4 continuounder load conditions simulated cold start at transfer of all EES loacompetent personnel stored energy power accordance with NFP circuit breakers are in program for periodica components is establemanufacturer requires readily available. EES circuits are marked, in separate from normat the possibility of dam source is a design coinstallations. 6.4.4, 6.5.4, 6.6.4 (NI 111, 700.10 (NFPA 70 This REQUIREMENT by: Based on record review on a revealed there was in monthly maintenance calendar year 2022 at 2. Record review on a calendar year 2022 at 2.	spected weekly, exercised s 12 times a year in 20-40 ercised once every 36 outs hours. Scheduled test include a complete ads, and are conducted by Maintenance and testing of sources (Type 3 EES) are in A 111. Main and feeder aspected annually, and a ally exercising the ished according to ments. Written records of ting are maintained and a lower circuits. Minimizing age of the emergency power insideration for new EPA 99), NFPA 110, NFPA 10) The is not met as evidenced item and interview, the ument generator kly or monthly testing.	KS	1. 2. 3.	All residents have the ptial to be affected. Deficient tice to be corrected moving ward. Education provided to retenance supervisor by 3/10 on the need for completing documenting weekly and megenerator maintenance. Edition also provided to maintenance supervisor by 3/10/2 on maintaining a path to the erator. The ED or designee will weekly times six weeks and monthly times three monthensure generator maintenance completed and documente that a path is maintained to generator. The ED or design will bring the results of the dits to the monthly QAPI content to the monthly QAPI content to continue or continue the audits.	t prac- for- main- /2023 and onthly uca- e- 023 e gen- audit as to ence is d and o the nee se au- emmit- recom-	3/16/23

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1989 ADDITION		(X3) DATE SURVEY COMPLETED		
		435086	B. WING		02/	14/2023	
	ROVIDER OR SUPPLIER W HEALTHCARE CENTE	ER .		6	STREET ADDRESS, CITY, STATE, ZIP CODE S11 EAST 2ND AVE FLANDREAU, SD 57028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 918	path through the snow Interview with the mai 2/14/23 at 3:00 p.m. r under load each mont Since this loaded test manufacturer he belief requirements.	nd 2023. There was also no v to the generator. intenance supervisor on evealed the generator ran th on the seventh at 10 a.m.	K	918			

South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED. AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 02/16/2023 10620 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **611 E 2ND AVE** RIVERVIEW HEALTHCARE CENTER FLANDREAU, SD 57028 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 S 000 Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/14/23 through 2/16/23. Riverview Healthcare Center was found not in compliance with the following requirements: S173 and S301. S 173 S 173 44:73:02:18(8-10) Occupant Protection 1. The light fixtures were replaced by 3/16/23 maintenance director or designee by 3/16/ The facility shall take at least the following 2023. All residents have the potential to precautions: be affected. (8) Any light fixture located over a resident bed, in any bathing or treatment area, in a clean supply 2. The ED will educate maintenance by 3/ storage room, in any laundry clean linen storage 16/2023 on the importance of lens covers area, or in any medication set-up area shall be on all light fixtures. The ED or designee equipped with a lens cover or a shatterproof will maintain a checklist to ensure all fixtures have a lens cover in place. (9) Any clothes dryer shall have a galvanized metal vent pipe for exhaust; and 3. The ED or designee will audit 4 ran-(10) The storage and transfilling of oxygen dom rooms weekly time four weeks and cylinders or containers shall meet the monthly times two months to ensure light requirements of the NFPA 99 Standard for Health fixture covers are in place. The ED or Care Occupancies, 2012 Edition. designee will take the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain lens covers for overhead lighting in two of two medication preparation rooms (first and second floor), dietary equipment storage room, and in the clean laundry. Findings include: 1. Observation on 2/14/23 at 10:15 a.m. revealed TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Timothy Yeaton

STATE FORM

Executive Director

(X6) DATE

3/9/2023

MAR 1 3 2022

ULNT11

If continuation sheet 1 of 4

South Dakota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING: __

(X3) DATE SURVEY COMPLETED B. WNG 10620 02/16/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID		
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETS DATE
t t t t t t t t t t t t t t t t t t t	the two two-bulb fixtures in the medication preparation room on first floor had no lens covers. Interview with the maintenance supervisor at the time of the observation confirmed that condition. 2. Observation on 2/14/23 at 10:45 a.m. revealed the four one-bulb fixtures in the dietary equipment storage room on first floor had no lens covers. Interview with the maintenance supervisor at the time of the observation confirmed that condition. 3. Observation on 2/14/23 at 11:15 a.m. revealed the two two-bulb fixtures in the clean laundry room on first floor had no lens covers. Interview with the maintenance supervisor at the time of the observation confirmed that condition. 4. Observation on 2/14/23 at 1:15 p.m. revealed the two two-bulb fixtures in the medication preparation room on second floor had no lens covers. Interview with the maintenance supervisor at the time of the observation confirmed that condition. 4:73:07:16 Required Dietary Inservice Training the dietary manager or the dietitian shall provide ingoing inservice training for all dietary and cod-handling employees. Topics shall include: and safety, handwashing, food handling and reparation techniques, food-borne illnesses, enving and distribution procedures, leftover od handling policies, time and temperature on trols for food preparation and service, nutrition and hydration, and sanitation requirements.	S 173	1. All dietary staff have completed the mandatory inservices required. All residents have the potential to be affected. 2. The ED or designee has educated all dietary staff on required topics prior to 3/16/2023. Any dietary staff that have not received training by 3/16/2-023 will be educated prior to their next working shift. 3. The ED or designee will audit monthly times six months that all newly hired dietary staff and current dietary staff have completed all necessary training per regulation. 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.	3/16/23

PRINTED: 03/01/2023 FORM APPROVED South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 02/16/2023 10620 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 611 E 2ND AVE RIVERVIEW HEALTHCARE CENTER FLANDREAU, SD 57028 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 301 S 301 Continued From page 2 Based on interview, and record review, the provider failed to ensure all dietary employees had received the required orientation and annual training. 1. Interview on 2/14/23 at 2:38 p.m. with dietary manager C revealed: *She had recently been hired on 2/6/23. *She was currently enrolled in a certified dietary manager training program and had until October 2023 to completed it. *A contracted registered dietician came in weekly. *She and another cook were Servsafe certified. *Dietary training had not been completed for the dietary staff since she started in her position. *There were ten employees that worked in dietary services. Interview and record review on 2/16/23 at 11:45 a.m. with human resources (HR) manager K regarding dietary staff training records revealed: *Training had not been completed since 9/5/22. *The consultant registered dietician had come to the facility and conducted training, but had not covered all of the required dietary areas. *Areas that had not been covered were: food safety, handwashing, food handling and preparation, foodborne illness, and sanitation. *There had been seven dietary employees hired after the 9/5/22 training had been completed. *Those employees included: -Dietary Manager C

If continuation sheet 3 of 4

ULNT11

hire.

p.m. revealed:

-Dietary Aides E, F, G, H, I, and J.

*HR manager K confirmed the above staff were to have had dietary orientation and training upon

Interview with administrator A on 2/16/23 at 4:00

*All newly hired staff are required to have

South Dakota Department of Health

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	WO MINTEL BARRIES	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
	IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED
		-	
	10620	B. WING	
			02/16/2023
NAME OF PROVIDER OR SUPPLIED		VE	

DER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RIVERVIEW HEALTHCARE CENTER

611 E 2ND AVE

(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) COMPLET DATE
S 301	Continued From page 3	S 301		
	orientation and training completed upon hire and annually. *He was aware the dietary staff training had not been up to date and should have been. *His expectation was for new hires and all staff to be up to date on their training.			
S 000	Compliance/Noncompliance Statement	S 000		
Walleton o of the community	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 2/14/23 through 2/16/23. Riverview Healthcare Center was found in compliance.			
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