DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 2/14/23 through 2/16/23. Riverview Healthcare Center was found not in compliance with the following requirements: F610, F657, F686, and F812. A complaint health survey 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 Center was found in compliance.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 610	1. A thorough investigation was completed on resident 16 and reported to DOH. All residents have the potential to be affected. 2. The ED and DNS were educated by the DDCO (Divisional Director of Clinical Operations) on conducting a thorough investigation and the Abuse policy by 3/14/2023. No changes were needed to the policy. The ED and DNS educated the Interdisciplinary team by 3/16/23. All those not in attendance will be educated prior to their next working shift. 3. The DDCO or designee will audit all reportable events monthly times six months to ensure an accurate and thorough investigation was completed. The DDCO 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

LABORATORY DIRECTOR'S OR PROVIDER/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 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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F 610	Continued From page 1 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 E-care [emergency] with order to send to ER (emergency room] for X-ray for further eval. [evaluation]." *A 2/1/23 at 11:29 p.m. IDT nursing progress note revealed: -"Late entry: CNA [certified nursing assistant] reported resident on the floor. She is on the floor	F 610		

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F 610	Continued From page 2 sitting position legs extended front of her w/c [wheelchair]." *A 2/1/23 at 10:31 p.m. IDT nursing progress note revealed: -"Resident returned coming from ER per ambulance @ 21:30 [9:30 p.m.]. With specific instructions. Pt. [patient/resident] placed in knee immobilizer." *A 2/2/23 at 9:04 a.m. IDT fall review late entry included information on the date, time, and location of the fall. The root cause investigation of the fall revealed: -"Amount of assistance an effect contributing factor of fall." -"Environmental factors/items out of reach contributing factor of fall." -"The following initial interventions have been put in place to prevent future falls. Staff to ensure proper positioning in wheel chair and recliner." Review of resident 16's 2/1/23 ED discharge plan revealed: *She had a fracture to her right femur. *Documentation by the ED provider included: -"Sounds as if staff at the nursing home trying to get her in the wheelchair slipped and then fell." -"X-rays taken of the hip and knee of that right lower extremity were taken. The right hip shows arthritic findings but no acute fracture. There does appear to be an abnormality associated with the right knee on the distal femur suggesting a supracondylar (above the knee) fracture which was reviewed by radiology as well." Interview on 2/16/23 at 1:02 p.m. with CNA/certified medication assistant (CMA) O regarding resident 16's fall revealed: *Resident 16 was usually assisted into her wheelchair before supper.	F 610		

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F 610	Continued From page 3 *She would frequently refuse to get into her wheelchair or recliner during the day. *Her transfer status was to use a full body lift and assistance of two staff. *She had just been assisted into her wheelchair. *She entered the room just as CNAs N and P had finished with the transfer with resident 16 and were leaving the room. *She had not noticed if she was positioned correctly in the wheelchair. *She had not been interviewed regarding the incident by administrator A or director of nursing (DON) B. Interview on 2/16/23 at 1:07 p.m. with CNA N regarding resident 16's fall revealed: *He had assisted resident 16 into her wheelchair with the full body lift with the assistance of CNA P. *He was sure that resident 16 had been positioned correctly in her wheelchair. *A few minutes after the staff had left her room he heard her yell "help." *When he went back into her room and she was sitting on the floor in front of her wheelchair. *The resident stated she had slipped out of her wheelchair. *He had not been interviewed regarding the incident by administrator A or DON B. Interview on 2/16/23 at 1:23 p.m. with occupational therapist Q regarding resident 16's fall revealed: *A request had been sent from nursing to assess resident 16's wheelchair and recliner seating. *Physical therapist (PT) R had completed that assessment. *She had not been interviewed regarding the incident by administrator A or DON B.	F 610		

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F 610	Continued From page 4	F 610		

Interview on 2/16/23 at 2:37 p.m. with CNA P regarding resident 16's fall revealed:
*She assisted resident 16 out of bed into her wheelchair with the full body lift.
*CNA N also assisted with the transfer.
*Resident 16 had not complained during the transfer.
*She and CNA N were the only staff in the room during the transfer of resident 16.
*She had not been interviewed regarding the incident by administrator A or DON B.

Interview on 2/16/23 at 3:04 p.m. with PT R revealed:
*She had assessed resident 16's wheelchair seating earlier in the day and found the size of the wheelchair was appropriate for her.
*She had not observed her in that wheelchair.
*She had not been interviewed regarding the incident by administrator A or DON B.

Interview on 2/16/23 at 4:30 p.m. with administrator A confirmed the incident on 2/1/23 of resident 16 falling out of her wheelchair. He reviewed the incident report and agreed a complete investigation had not been completed per the provider's policy. He would have expected interviews of all staff involved.

Review of the South Dakota Department of Health 2/1/23 reportable incident report submitted by the provider revealed:
*Resident 16 was not interviewed regarding the incident.
*None of staff involved had been interviewed regarding the incident.
*No neglect or abuse had been substantiated by the provider.
*The conclusionary summary was the IDT nursing

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F 610	Continued From page 5 progress notes: -"Writer was notified at 1730 [5:30 p.m.] that resident slid out of her wheel chair and was found on the floor. She was in new pain in her R [right] extremity. She was assisted back into bed with Hoyer lift. Avel ecare was notified and updated and they stated that if [resident] wanted to go to ER to be evaluated that would be okay. Daughter was notified and agreed with the plan of sending to ER if [resident] wanted to go. [Resident] wanted to go to ER for evaluation and was transferred to the ER via ambulance at 1630 [4:30 p.m.]. [Resident] was evaluated in the ER and x-ray were taken of her R [right] hip and knee. X-ray of the hip showed arthritic findings but no acute fracture. The R [right] knee did show an abnormality of the R [right] knee on the distal femur suggesting a supracondylar fracture. [Resident] was placed in an immobilizer of the R [right] leg and sent back to facility with orders to keep knee immobilizer in place at all times unless during cares. Due to [resident] morbid obesity and non-weight bearing status prior to injury she was not a surgical candidate." -"Fall intervention: Staff to ensure proper positioning in wheel chair and recliner when out of bed.' Review of the provider's updated October 2023 Abuse Investigation policy revealed: *"The executive director is the designated abuse coordinator and is responsible for assigning and overseeing staff that are to assist with investigations." *The provider would have identified and interviewed involved persons. *With a through investigation, the provider would have worked to determine if abuse, neglect, exploitation, and/or mistreatment had occurred	F 610		

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F 610	Continued From page 6 and would have determined the extent and cause. *The provider would have maintained a complete and thorough record of documentation of the investigation.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 657	1. Residents 12, 16, 29, and 30 have had a comprehensive review of their care plans. All resident care plans reviewed for appropriate interventions. All residents have the potential to be affected. 2. The DNS or designee will educate the interdisciplinary team and licensed nurses on ensuring an accurate and timely care plan is in place for all residents by 3/16/23. All those not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit four random care plans weekly times eight weeks for accuracy and timeliness. The DNS 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.	3/16/23

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F 657	Continued From page 7 and Minimum Data Set (MDS) contractor agreement, the provider failed to ensure care plans had been reviewed and revised to ensure they accurately reflected the residents care needs for 4 of 13 sampled residents (12, 16, 29, and 30.) Findings include: 1. Observation and interview on 2/15/23 at 1:45 p.m. with resident 16 revealed she had: *A compression stocking on her left leg. *A full leg brace on her right leg. *Slipped out of her wheelchair and fractured her right knee cap. *Pain when she was repositioned from side to side in her bed. *After she fell and fractured her right knee cap she stayed in her bed at all times. *A urinary catheter. *Open areas to her skin on her bottom. Review of resident 16's medical record revealed: *She had been admitted on 12/21/22 from the hospital. *Her diagnoses included: pressure ulcers to her left hip, right hip, and sacrum (area above the sitting bone [coccyx]). edema, congestive heart failure, obesity, and cellulitis to right and left lower legs. *She had a fall out of her wheelchair on 2/1/23 and sustained a fracture to her right leg. Review of resident 16's 1/3/23 care plan revealed: *There was no focus, goal, or interventions related to her fall from her wheelchair with injury on 2/1/23. *There was a focus area that she was at low risk for falls. *There was no focus, goal, or interventions for	F 657		

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F 657	Continued From page 8 dietary interventions related to her impaired skin integrity. *The focus, goal, and interventions for her impaired skin integrity did not include all areas involved and interventions currently in place. 2. Observation and interview on 2/14/23 at 4:45 p.m. with resident 29 revealed: *He was seated in a recliner in his room. -Stated he slept in his recliner. -There was no bed on his side of the room. *The recliner had no pressure relieving or reducing cushion. *His feet were not elevated at that time. *He stated he had a sore on his bottom and a bad infection on his leg. *His right lower leg revealed his skin was very dark and red. There were no open areas and no drainage was noted. There were no dressings on his leg. Review of resident 29's 1/16/23 care plan revealed: *There was a focus area related to his skin break down with interventions that had included: -Having a pressure reducing cushion when he was up in his chair. -Having a pressure reducing mattress on his bed. Interview on 2/16/23 at 3:30 p.m. with director of nursing (DON) B and regional nurse consultant M regarding the reviews and the updating of resident care plans as needs and care changed revealed: *They agreed resident care plans were not updated in a timely manner. *The provider contracted with a company who does the MDS and the assistant director of nursing completed the care plan.	F 657		

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F 657	Continued From page 9 *Agreed they do not have an actual process to ensure resident care plans reflected the residents current care needs. 3. Observation and interview on 2/14/23 at 4:30 p.m. with resident 30 revealed he: *Was sitting in a recliner in his room with his feet elevated. *Had a Prevalon boot placed on his left foot. Review of resident 30's medical record revealed: *He had been admitted on 4/24/20. *His 12/20/22 brief interview for mental status (BIMS) score was 15, indicating his cognition was intact. *His diagnosis included: Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, heart failure, atrial fibrillation, chronic pain syndrome, type II diabetes, and disorder of the skin and subcutaneous tissue. *He had an unstageable pressure ulcer to his left heel from 3/9/22 through 3/30/22. *On 12/17/23 he was found to have developed an unstageable pressure ulcer to his left heel again. -The pressure ulcer was healed on 1/9/23. Review of resident 30's 11/10/22 care plan revealed the Prevalon boot was not included as an intervention in his care plan. Refer to F686, finding 1. 4. Review of resident 12's medical record revealed: *He had been admitted on 8/9/22. *His 12/19/22 BIMS score was 6, indicating his cognition was severely impaired. *He had been admitted to hospice care on 2/1/23.	F 657		

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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 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.	F 657		
F 686 SS=G	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	See next page	

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F 686	Continued From page 11 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure two of four sampled residents (12 and 30) who were at risk of skin breakdown had: *Preventative measures implemented to prevent pressure ulcers from developing. *Care plans updated to reflect the current interventions to prevent skin breakdown. Findings include: 1. Observation on 2/14/23 at 10:58 a.m. of resident 30 revealed he: *Was sleeping in a recliner in his room with his feet elevated. *Had a Prevalon boot (cushioned boot that floats the heel to reduce pressure) under his left ankle propping his heel off the footrest of the chair. Review of resident 30's medical record revealed: *He had been admitted on 4/24/20. *His 12/20/22 Brief Interview for Mental Status (BIMS) score was 15, indicating his cognition was intact. *His diagnosis included: Hemiplegia and hemiparesis following cerebral infarction affecting	F 686	1. A comprehensive review of resident 12 and 30 care plan was completed by 3/14/23 to ensure appropriate interventions are in place. All residents at risk were reviewed and appropriate interventions are in place. All residents have the potential to be affected. 2. The ED, DNS and interdisciplinary team reviewed the skin policy by 3/13/23 No changes were needed in the policy. The DNS or designee educated all nursing staff on their role and responsibility in the prevention of pressure ulcers as well as their responsibility in identifying and implementing, documenting and care planning preventative measures and approaches by 3/16/23. All staff not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit 4 random residents at risk for skin breakdown to ensure appropriate interventions are in place and documented to prevent pressure ulcers weekly time four weeks and monthly times two months. The DNS 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.	3/16/23

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F 686	Continued From page 12 left non-dominant side, heart failure, atrial fibrillation, chronic pain syndrome, type II diabetes, and disorder of the skin and subcutaneous tissue. *His 12/20/22 Braden Scale for predicting pressure ulcer risk score showed he was at moderate risk. *He had an unstageable pressure ulcer to his left heel from 3/9/22 through 3/30/22. -No other interventions had been documented after the pressure ulcer had developed. *On 12/17/23 he was found to have re-developed the unstageable pressure ulcer to his left heel. -No other interventions had been documented after the pressure ulcer had re-developed. -The pressure ulcer was healed on 1/9/23. *He had an order for an ankle-foot orthosis (AFO) brace to his left foot as needed. *The Prevalon boot was not documented in the resident's medical record. Review of resident 30's 11/10/22 care plan revealed: *He was at risk for skin breakdown. *He had a pressure ulcer on his left heel from 3/9/22 through 3/30/22. *The goal was "I want my skin to remain intact through the review date." *Interventions included: -"Assess/record/monitor wound healing - Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD [medical doctor]." -"Encourage/assist me to apply lotion to dry skin." -"Follow facility policies/protocols for the prevention/treatment of skin breakdown." -"I use a pressure relieving mattress on my bed,	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 686	Continued From page 13 and pressure reducing cushion in my wheelchair." -"Use bilateral assist bars with encouragement to assist with turning/repositioning in bed. Please cue me to use." *No new interventions had been implemented since 6/17/22. *The Prevalon boot was not included in the interventions. Interview on 2/16/23 at 4:30 p.m. with director of nursing (DON) B regarding resident 30 revealed: *He had COVID-19 in early December 2022 and his health had declined. *He had been hospitalized and returned to the facility on 12/15/22. *He had not worn the AFO since he returned from the hospital because he was not walking. *She did not know when the Prevalon boot was implemented, but had stated it was not until after he returned from the hospital. *The skin assessment was completed on 12/15/22 when he returned from the hospital and there was not documentation that indicated a pressure ulcer to his left heel. *The care plan should have included the Prevalon boot. *His medical record should have reflected the interventions put into place after he had developed the pressure ulcer. 2. Observation on 2/14/23 at 2:45 p.m. of resident 12's room revealed he had a heel lift pillow (used to relieve pressure on heels) on the foot of his bed. Observation on 2/16/23 at 8:30 a.m. of resident 12 revealed he was laying in his bed asleep with his lower legs rested on the heel lift pillow.	F 686		

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F 686	Continued From page 14 Review of resident 12's medical record revealed: *He had been admitted on 8/9/22. *His 12/19/22 BIMS score was 6 indicating his cognition was severely impaired. *He had been admitted to hospice care on 2/1/23. *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. *The certified nurse practitioner's note from 1/24/23 revealed he had a blister to the back of his right heel and she had questioned if it was caused from friction. *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 buttock. -The 2/15/23 nurses note did not specify where it was located on his bottom. -A new wheelchair cushion was implemented and an air mattress was requested from hospice. Review of resident 12's weekly skin evaluations from 1/30/23 through 2/13/23 revealed: *He had a blister on his right heel. *Did not indicate if the blister to his right heel was a pressure ulcer or caused from friction. Interview on 2/16/23 at 8:59 a.m. with registered nurse L revealed: *He had a pressure ulcer on his right heel and the dressing change had been completed. *He had a wound on his bottom she needed to assess and treat. *She stated she would have a surveyor look at the wound when she was ready to complete the treatment. *She had not let the survey team know when she	F 686		

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F 686	Continued From page 15 had done the treatment. Review of resident 12's care plan revealed: *He was at risk for skin breakdown. *He had a wound on his right heel and open area on his buttock. *The goal was "I want to be free of skin injuries through the review date." *The interventions included: -"Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short." -"Educate resident/family/caregivers of causative factors and measures to prevent skin injury." -"Follow facility protocols for treatment of injury." -"Identify/document potential causative factors and eliminate/resolve where possible." -"Keep skin clean and dry. Use lotion on dry skin." -"The resident needs pressure reducing mattress on bed to protect the skin while IN BED." -"Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations." -"Pressure reducing cushion in wheelchair." *No new intervention had been implemented since 11/21/22. *The egg crate boot had not been included in the care plan. *The heel lift pillow was not included in the care plan. 3. Review of the provider's October 2022 Skin Integrity policy revealed: *"The nurse establishes a Plan of Care (POC) based on risk factors in an effort to limit their potential effects." *When a resident developed a skin impairment, interventions should have been implemented and	F 686		

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F 686	Continued From page 16 documented on the care plan.	F 686		
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 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the provider failed to ensure a clean and sanitary environment had been maintained for one of one main kitchen and two of two kitchenettes that provided food service to all 49 residents in the facility. Findings include: 1. Observation and interview on 2/14/23 at 2:38 p.m. with dietary manager C during the kitchen tour revealed: *A room next to the main kitchen area contained an uncovered large standing mixer.	F 812	1. A cover has been placed on mixer, electrical panel has been sanded and painted, window screen has been cleaned and AC units properly sealed by 3/16/23. A contractor has submitted a bid to repair ceiling and replace cupboards prior to 6/1/2023. All residents have the potential to be affected. 2. The ED or designee has educated maintenance and dietary manager on the deficient practice and maintaining a safe and sanitary kitchen by 3/16/23. 3. The ED or designee will audit the kitchen monthly times six months to ensure a safe sanitary environment. 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

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F 812	Continued From page 17 *The dietary staff called it "the baking room" because baked goods had been mixed and prepared there. *There had been a small prepping counter area and cupboards used for storage of baking supplies. *The ceiling above the room had significant water damage. -The paint was cracked, peeling and flaking off of the ceiling surface. -There was a round hole about 6 inches in circumference where the dry wall was exposed and had fallen out. *An ice machine had been located above the baking room on the second floor and had leaked which caused the water damage. *The water damage had happened prior her start date. *An electrical box next to the elevator with the bottom third of the box rusted and an uncleanable surface. Observation on 2/14/23 at 2:45 p.m. of the dishroom area revealed: *Paint cracked, flaked, and peeling off of the ceiling above the dishwasher, and dish work area. *The designated clean area was within a few feet of the damaged ceiling. -There were clean, uncovered glasses in the dish racks stacked and stored there. Observation on 2/14/23 at 3:11 p.m. of the main kitchen revealed: *A screened-in window had been opened by dietary staff due to the heat in that area. -The opened window's screen had fuzz, dust, and dark particles stuck to the surface. *A long table was located near the windows	F 812		

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F 812	Continued From page 18 where food was prepared. *Two window air conditioner (AC) units had been placed with a wooden surround above the window area. -The AC units were not well sealed from the outdoor elements. -The vents to both of the AC units were covered with a dark and fuzzy debris. -Cobwebs with dark debris surrounded both AC units. *The ceiling above the food preparation area had cracked, flaked, and peeling paint. *There were exposed electrical wires that were located next to the window frame. Observation on 2/13/23 at 3:18 p.m. of the two kitchenette on second floor revealed: *The cupboard areas under both kitchenette sinks had wooden particle board that was water damaged, unsealed, and crumbling. *Those surfaces were not cleanable surfaces. Interview on 2/16/23 at 10:31 a.m. with dietary manager C revealed: *Confirmation that the above observations were accurate. *She agreed: -Ceiling areas that are peeling, cracked and flaking off should have been repaired and repainted. -The standing mixer should have been moved to another area for food preparation and covered when not in use. -The rusted electrical box should have been stripped and repainted. -The dishroom should not have been used to store clean dishes in its current condition. -Staff had regularly opened the kitchen windows to keep the area cool.	F 812		

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F 812	Continued From page 19 -Window screens should have been clean if opened to cool the kitchen. -The cobwebs around the AC units had been overlooked and should have been removed. -Any areas with bad paint should have been repaired and repainted. -All of the areas would have been concern for possible contamination of foods being prepared for the residents. -She had just started making a new cleaning and maintenance schedule/checklist for the dietary staff to follow. Interview on 2/16/23 at 3:45 p.m. with administrator A revealed: *He was in agreement there was repair work that needed to have been completed regarding the above observations. *The water damage to the kitchen areas and dishroom from the ice machine had happened four or five or weeks ago. *He agreed those areas should been fixed as soon as possible. *The AC units should have been sealed and free from dirt, cobwebs, and debris. *The water damaged cupboards below the kitchenette sinks should have been repaired. *He would expect the dietary staff to keep the kitchen environment clean and sanitary to prevent any infection control safety concerns for the residents.	F 812		

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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 2/14/23 through 2/16/23. 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* | *3/9/2023*

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 made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	435086	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/14/2023

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/14/23. Riverview Healthcare Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K223, K271, K353, K355, K712 and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain six areas required to be protected by a self closing door (north stairwell at first level, resident room 9 being used as storage,	K 223	1. All residents have the potential to be affected 2. All exit passageways, stairway enclosures, smoke barriers, and hazardous area enclosures have been equipped with automatic closures by 3/10/2023. ED educated Maintenance on requirement for doors with self-closing devices by 3/10/2023. 3. The ED or designee will audit all doors monthly times six months to ensure all exit passageways, stair enclosures, horizontal exits, smoke barriers, or hazardous areas have functional closures that automatically close all such doors. 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

LABORATORY DIRECTOR'S OR PROVIDER/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 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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K 223	Continued From page 1 resident room 11 being used as storage, resident room 13 being used as storage, clothing room at the front entry, and laundry room) as required. Findings include: 1. Observation on 2/14/23 at 10:15 a.m. revealed the north stairwell door on first floor no longer had a closer installed on the door as required by code. 2. Observation on 2/14/23 at 10:25 a.m. revealed resident room 9 was being used as storage, was over one hundred square feet, and did not have a closer installed on the door as required by code. 3. Observation on 2/14/23 at 10:30 a.m. revealed resident room 11 was being used as storage, was over one hundred square feet, and did not have a closer installed on the door as required by code. 4. Observation on 2/14/23 at 10:35 a.m. revealed resident room 13 was being used as storage, was over one hundred square feet, and did not have a closer installed on the door as required by code. 5. Observation on 2/14/23 at 11:10 a.m. revealed the clothing room, used for storage of charitable items, was over one hundred square feet, and did not have a closer installed on the door as required by code. 6. Observation on 2/14/23 at 11:25 a.m. revealed the laundry room was over one hundred square feet and considered hazardous, and did not have a latching door as required by code. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiencies had the potential to affect 100%	K 223		

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K 223	Continued From page 2 of the occupants of the smoke compartment where they were located.	K 223		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide a clear egress discharge path to the public way. One of seven exit discharge paths (west wing, second level) was not cleared of snow. Findings include: 1. Observation on 2/14/23 at 1:45 p.m. revealed the exit discharge from the west resident wing second level was not cleared of snow to the public way. Measuring revealed approximately 15 inches of snow was on the egress path. Interview with the maintenance supervisor at the time of the observation confirmed that condition. The deficiency had the potential to affect 100% of the smoke compartment occupants.	K 271	1. All residents have the potential to be affected. 2. All outdoor exits have been cleared of snow by 3/10/2023. ED educated Maintenance on ensuring all outdoor exits provide a clear egress discharge path by 3/10/2023. 3. The ED or designee with audit all outdoor exits weekly for remainder of 2023 snow season. 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
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353	See next page	

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

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K 353	Continued From page 3 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test not done during the past twelve months). Findings include: 1. Observation on 2/14/23 at 11:30 a.m. showed standpipe tags on the sprinkler system were only available for the annual testing of the system. Record review on 2/14/23 at 2:30 p.m. revealed the required quarterly flow tests had not been performed in the past year by the contractor. Interview with maintenance supervisor at the time of the record review confirmed he had not performed any quarterly flow tests. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required	K 353	1. All residents have the potential to be affected. 2. The sprinkler system company will train maintenance director on quarterly flow testing by 4/1/2023. The ED educated the maintenance director on the importance of quarterly flow testing by 3/10/2023. 3. The ED or designee will audit quarterly times two quarters that the flow testing has been completed and training on flow testing has occurred. 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.	3/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
K 353	Continued From page 4 tests on the automatic sprinkler system.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to properly maintain fire extinguishers in the first floor resident living area (north and west wings of first floor). 1. Observation and interview on 2/14/23 beginning at 10:15 a.m. and extending until 11:30 a.m. revealed all extinguishers in the north and west wings of first floor were missing the January, 2023 inspection. Interview with the environmental services director at the time of the observation confirmed that finding. He was not aware how to perform the monthly check. The deficiency has the potential to affect both smoke compartments.	K 355	1. All residents have the potential to be affected. All fire extinguishers have been inspected prior to 3/10/2023. 2. The ED educated maintenance director on the importance of monthly fire extinguisher inspections and maintenance by 3/10/2023. 3. The ED or designee will audit all fire extinguishers monthly times four months for timely inspection and maintenance. 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
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at	K 712	See next page	

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	435086	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/14/2023

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

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K 712	Continued From page 5 least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to: *Maintain documentation of fire drills for the past year. *Hold fire drills at varying times during the past year. *Document transmission of the fire alarm signal during the drills. *Ensure staff were familiar with fire drill procedures. Findings include: 1. Record review on 2/14/23 at 2:30 p.m. revealed there were no records for fire drills. 2. Interview with the administrator at the time of the record reviews confirmed those findings. He stated there had been drills conducted. However no documentation of the drills was provided and he stated he knew that was a problem. The deficiency had the potential to affect 100% of the building occupants.	K 712	1. All residents have the potential to be affected. Deficient practice to be corrected moving forward. 2. Education provided to maintenance supervisor by 3/10/2023 on timely practice of fire drills. 3. The ED or designee will conduct a monthly audit for 12 months to ensure adequate number of fire drills completed. 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
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918	See next page	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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

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K 918	Continued From page 6 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to document generator maintenance for weekly or monthly testing. Findings include: 1. Record review on 2/14/23 at 2:35 p.m.	K 918	1. All residents have the potential to be affected. Deficient practice to be corrected moving forward. 2. Education provided to maintenance supervisor by 3/10/2023 on the need for completing and documenting weekly and monthly generator maintenance. Education also provided to maintenance supervisor by 3/10/2023 on maintaining a path to the generator. 3. The ED or designee will audit weekly times six weeks and monthly times three months to ensure generator maintenance is completed and documented and that a path is maintained to the generator. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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K 918	Continued From page 7 revealed there was no documentation of the monthly maintenance for the generator for calendar year 2022 and 2023. 2. Record review on 2/14/23 at 2:35 p.m. revealed there was no documentation of the weekly maintenance for the generator for calendar year 2022 and 2023. There was also no path through the snow to the generator. Interview with the maintenance supervisor on 2/14/23 at 3:00 p.m. revealed the generator ran under load each month on the seventh at 10 a.m. Since this loaded test was preset by the manufacturer he believed the loaded test met all requirements. The deficiency affected 100% of the building occupants.	K 918		

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	435086	A. BUILDING 02 - 1989 ADDITION B. WING _____	02/14/2023

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

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/14/23. Riverview Healthcare Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K353, K712 and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353	1. All residents have the potential to be affected. 2. The sprinkler system company will train maintenance director on quarterly flow testing by 4/1/2023. The ED educated the maintenance director on the importance of quarterly flow testing by 3/10/2023. 3. The ED or designee will audit quarterly times two quarters that the flow testing has been completed and training on flow testing has occurred. 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.	3/16/23

LABORATORY DIRECTOR'S OR PROVIDER/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 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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K 353	Continued From page 1 Based on observation, record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test not done during the past twelve months). Findings include: 1. Observation on 2/14/23 at 11:30 a.m. showed standpipe tags on the sprinkler system were only available for the annual testing of the system. Record review on 2/14/23 at 2:30 p.m. revealed the required quarterly flow tests had not been performed in the past year by the contractor. Interview with maintenance supervisor at the time of the record review confirmed he had not performed any quarterly flow tests. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic sprinkler system.	K 353	1. All residents have the potential to be affected. Deficient practice to be corrected moving forward. 2. Education provided to maintenance supervisor by 3/10/2023 on timely practice of fire drills. 3. The ED or designee will conduct a monthly audit for 12 months to ensure adequate number of fire drills completed. 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
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K 712		

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	435086	A. BUILDING **02 - 1989 ADDITION** B. WING _____	**02/14/2023**

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K 712	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to: *Maintain documentation of fire drills for the past year. *Hold fire drills at varying times during the past year. *Document transmission of the fire alarm signal during the drills. *Ensure staff were familiar with fire drill procedures. Findings include: 1. Record review on 2/14/23 at 2:30 p.m. revealed there were no records for fire drills. 2. Interview with the administrator at the time of the record reviews confirmed those findings. He stated there had been drills conducted. However he would not produce any documentation of the drills and stated he knew that was a problem. The deficiency had the potential to affect 100% of the building occupants.	K 712		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918	See next page	

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K 918	Continued From page 3 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to document generator maintenance for weekly or monthly testing. Findings include: 1. Record review on 2/14/23 at 2:35 p.m. revealed there was not any documentation of the monthly maintenance for the generator for calendar year 2022 and 2023. 2. Record review on 2/14/23 at 2:35 p.m. revealed there was no documentation of the weekly maintenance for the generator for	K 918	1. All residents have the potential to be affected. Deficient practice to be corrected moving forward. 2. Education provided to maintenance supervisor by 3/10/2023 on the need for completing and documenting weekly and monthly generator maintenance. Education also provided to maintenance supervisor by 3/10/2023 on maintaining a path to the generator. 3. The ED or designee will audit weekly times six weeks and monthly times three months to ensure generator maintenance is completed and documented and that a path is maintained to the generator. 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

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K 918	Continued From page 4 calendar year 2022 and 2023. There was also no path through the snow to the generator. Interview with the maintenance supervisor on 2/14/23 at 3:00 p.m. revealed the generator ran under load each month on the seventh at 10 a.m. Since this loaded test was preset by the manufacturer he believed the loaded test met all requirements. The deficiency affected 100% of the building occupants.	K 918		

South Dakota Department of Health

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	10620	A. BUILDING: _____ B. WING _____	02/16/2023

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

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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 2/14/23 through 2/16/23. Riverview Healthcare Center was found not in compliance with the following requirements: S173 and S301.	S 000		
S 173	44:73:02:18(8-10) Occupant Protection The facility shall take at least the following precautions: (8) Any light fixture located over a resident bed, in any bathing or treatment area, in a clean supply storage room, in any laundry clean linen storage area, or in any medication set-up area shall be equipped with a lens cover or a shatterproof lamp; (9) Any clothes dryer shall have a galvanized metal vent pipe for exhaust; and (10) The storage and transfilling of oxygen cylinders or containers shall meet the requirements of the NFPA 99 Standard for Health Care Occupancies, 2012 Edition. 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	S 173	1. The light fixtures were replaced by maintenance director or designee by 3/16/2023. All residents have the potential to be affected. 2. The ED will educate maintenance by 3/16/2023 on the importance of lens covers on all light fixtures. The ED or designee will maintain a checklist to ensure all fixtures have a lens cover in place. 3. The ED or designee will audit 4 random rooms weekly time four weeks and monthly times two months to ensure light fixture covers are in place. The ED or designee will take the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	3/16/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Timothy Yeaton — TITLE: Executive Director — (X6) DATE: 3/9/2023

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	10620	A. BUILDING: _____ B. WING _____	02/16/2023

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S 173	Continued From page 1 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.	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
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by:	S 301		

South Dakota Department of Health

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	10620	A. BUILDING: _____ B. WING _____	02/16/2023

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RIVERVIEW HEALTHCARE CENTER	611 E 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) COMPLETE DATE
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 -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 hire. Interview with administrator A on 2/16/23 at 4:00 p.m. revealed: *All newly hired staff are required to have	S 301		

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 _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 301	Continued From page 3 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 301		
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 2/14/23 through 2/16/23. Riverview Healthcare Center was found in compliance.	S 000		