STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(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 12/6/22 through 12/8/22. White River Health Care Center was found not in compliance with the following requirement: F550.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550	F550 Resident Rights/Exercise of Rights Resident #1 had no identified negative outcomes resulting in improper dignity and safety during a transfer All residents have the potential to be affected. 1:1 verbal education was conducted with identified C.N.A.'s G on 12/23/2022 by DON Assistant. The C.N.A. H. is contract C.N.A. and is no longer in the facility. Administrator and/or Designee will re-education of following policies: Resident's Rights identifying respect and dignity, quality care, exercise rights, ensure resident can exercise rights without interference, coercion, discrimination, or reprisal from the facility, resident is to be supported by the facility in exercising of their rights as required, and gait belt and competency on proper use of gait belts for all licensed nursing staff started on 12/21/2022 with emphasis on all topics involving dignity and safety during transfers. The staff that did not attend in-service on 12/21/22 those who were not educated before 12/28/22 will be educated before their next scheduled shift.	12/28/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda L Hodges — TITLE: Administrator — (X6) DATE: 1/3/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and the provider's admission resident rights document review, the provider failed to ensure that: *Dignity and safety was maintained for one of one sampled resident (1) during one of one observed transfer from bed to wheelchair by two of two certified nursing assistants (CNA) (G and H). *One of one observed medication cart had confidential information out of the sight of visitors. Findings include: 1. Observation and interview on 12/6/22 at 11:45 a.m. of CNAs G and H helping resident 1 to transfer from his bed to his wheelchair revealed: *They had helped him to a sitting position on his bed, then without using a gait belt, each had pulled on the back of his pants and pivoted him to the wheelchair. *Two gait belts were noted hanging on separate hooks in his room. *When asked about the observation and the lack of gait belt use, they both said, "We usually use a gait belt to transfer him." Review of resident 1's care plan revealed he had	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(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 550	Continued From page 2 required a "pivot transfer with two staff helping. Use gait belt for transfers." Interview on 12/7/22 at 1:35 p.m. with CNA G when asked why they did not use the gait belt to transfer resident 1 she stated, "I just spaced out using it [the gait belt]." Interview on 12/7/22 at 1:43 p.m. with director of nursing (DON) B regarding resident 1's transfer revealed, "They should not be using the back of his pants to transfer him. They should be using a gait belt." She agreed to transfer him in this manner did not promote his dignity. Review of the provider's 7/1/22 Attachment I Resident Rights in the admission packet revealed, "Each resident has the right to a dignified existence, self-determination, and communication..... " 1. Observation on 12/7/22 at 4:45 p.m. of the east medication cart revealed the 12/7/22 shift report sheet laying on top in full view of anyone passing by. This sheet had private health information of every resident in the building. The information included: *Medication residents received, including insulin. *Fall risks. *Remove dentures. *Wound care. *Toileting assistance or use of an incontinence product. *Elopement risk. *Check closet for soiled clothes. Interview on 12/8/22 at 2:00 p.m. with licensed practical nurse (I) revealed she had not realized she had the "report sheet" out in plain view. She	F 550	All residents have the potential to be affected. 1:1 verbal education was conducted with identified LPN (I) Confidentiality of resident records, and HIPPA on 12/23/22. Re-education of following policies: Confidentiality of resident records, HIPAA, and release of information done on 12/21/22. The staff that did not attend the in-service on 12/21/22 will be educated before their next scheduled shift. The DON and/or designee will conduct random audits weekly on five residents per week to ensure dignity and safety are maintained during the transfer while using a gait belt. The DON and/or designee will conduct these audits weekly x 4 weeks, monthly x 3 and then quarterly thereafter. Results will be submitted by DON and/or designee through the QA/QAPI process for review/recommendations monthly. Any patterns will be identified.	12/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(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 550	Continued From page 3 usually "puts it under the computer when she is away from the medication cart." Interview on 12/8/22 at 2:10 p.m. with DON A revealed she, "expected the nurses to keep confidential information out of public view. I have to continually remind them of this almost daily." Review of the provider's 7/1/22 Attachment I Resident Rights in the admission packet revealed, "Each resident has the right to confidential handling of his/her medical and personal records and will only be released with the resident's prior written consent."	F 550		

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
	43A089	A. BUILDING _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 12/6/22 through 12/8/22. White River Health Care Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda J Hodges
TITLE: Administrator
(X6) DATE: 12/28/22

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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
	43A089	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(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 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 12/6/22. White River Health Care 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 K291, K355, K918 and K920 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain battery pack emergency lighting for the electrical switch gear. Findings include: Observation on 12/07/22 at 11:15 a.m. revealed the battery pack emergency light for the electric switchgear located in the boiler room would not illuminate. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The maintenance supervisor also commented that though he checked the light frequently, he did not keep records of those checks. The deficiency affected one of numerous	K 291	An emergency lamp was purchased and installed on 12/13/2022. A checklist was made and given to the Maintenance Director on 12/21/2022. All residents had the potential to be affected, however they were not affected. The Maintenance Director will complete a monthly audit ensuring the emergency light is working properly. The audits rounds will be completed monthly x's six months then randomly after that point to ensure that compliance is maintained. Results will be submitted through the QA/QAPI process for review/recommendations. Patterns will be addressed	12/28/2022 BH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mandi L Hodges
TITLE: Administrator
(X6) DATE: 12/26/22

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(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 291	Continued From page 1 requirements for the emergency lighting system.	K 291		
K 355 SS=E	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 the fire extinguishers throughout the building. Findings include: Observation and interview on 12/06/22 during the building tour revealed all extinguishers had received the required monthly checks, but had not had the required annual inspection since June 2021. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he has the company scheduled to come this month. The deficiency has the potential to affect all residents and staff in the building.	K 355	Rapid Fire completed the Annual inspection on 12/19/2022 all fire extinguishers received annual inspection during the annual inspection. All Residents had the potential to be affected, however, they were not affected. The Maintenance Director will be given a checklist to sign off when inspections are to occur. The Maintenance Director will do an audit on the annual inspections for the fire extinguisher monthly with checklist provided by the Administrator. The Administrator will monitor the checklist assuring checklist is completed. Results will be submitted through the QA/QAPI process for review/recommendations. Any patterns will be identified.	12/28/2022
K 918 SS=E	The deficiency has the potential to affect the entire smoke compartment. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(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 918	Continued From page 2 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 perform generator maintenance as required (monthly load runs) for the propane generator for 2022. Findings include: 1. Record review revealed documentation of	K 918	The generator was reset to run in 30 minute (0.5 hour) plus a minimum five minutes (0.01) cool down time delay. The Maintenance Director records weekly with checklist to ensure electrical systems (generator) monthly load runs for 30 minutes plus a minimum five-minute cool down time delay. Maintenance Director will audit weekly to ensure drills are completed. This will include weekly runs, cool down times, dates, times, and days with various other required information. Will be reviewed at QA/QAPI monthly for six months or until substantial compliance is obtained.	12/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A089	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/06/2022

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WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

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K 918	Continued From page 3 generator load runs were for twenty minutes each week. The weekly runs are automated, and the maintenance supervisor documents data during each run. However, the twenty-minute run does not meet the requirement for a thirty-minute load test. Interview with the maintenance supervisor on 12/07/22 at 2:30 p.m. during the record review confirmed that finding. The monthly load runs must be for thirty minutes (0.5 hours) plus a minimum five minute (0.1 hour) cool down time delay. Further interview with the maintenance supervisor revealed he was doing the five-minute cool down as required. The deficiency affected one of numerous generator maintenance requirements.	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a	K 920	The Administrator contacted the Rosebud Sioux Tribe Water Resource about the geo-thermal system adding permanent wiring instead of using an extension cord from the facility for the heating tape. The Maintenance Director will monitor and audit the extension cord is not used monthly. Administrator and/or Designee will monitor the progress of working with Rosebud Sioux Tribe Water Resources. Results of audit will be submitted to the QA/QAPI process for review/recommendation for any patterns will be identified and monitored.	12/28/2022 BH

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
	43A089	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET WHITE RIVER, SD 57579

(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 920	Continued From page 4 substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to ensure extension cords were not used as a substitute for fixed wiring in one randomly observed location (extending from a nursing home window to the geo-thermal system outside). Findings include: Observation revealed the geo-thermal system at the northwest corner of the property had heat tape applied to protect from cold temperatures. That heat tape was powered by an extension cord from inside the nursing home instead of permanent wiring. Interview with the maintenance supervisor on 12/07/22 at 1:40 p.m. confirmed the finding. The heat tape was installed by others who are responsible for the geo-thermal system. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 920		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10710	A. BUILDING: _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER HEALTH CARE CENTER	515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD 57579

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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 12/6/22 through 12/8/22. White River Health Care Center was found in compliance.	S 000		
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 12/6/22 through 12/8/22. White River Health Care Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brandi J Hodges TITLE: Administrator (X6) DATE: 12/28/22