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	02/16/2023

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26632 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 [DATE]. *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 sitting position legs extended front of her w/c [wheelchair]. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*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. *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: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*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. 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 and would have determined the extent and cause. *The provider would have maintained a complete and thorough record of documentation of the investigation.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26632 Based on observation, interview, record review, 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 [DATE] 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 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. *Agreed they do not have an actual process to ensure resident care plans reflected the residents current care needs. 41895 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 [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*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 [DATE]. *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. *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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41895 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 [DATE]. *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. *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. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	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, 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 [DATE]. *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. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	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. Review of resident 12's medical record revealed: *He had been admitted on [DATE]. *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 had done the treatment. Review of resident 12's care plan revealed: *He was at risk for skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*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 documented on the care plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41088 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. *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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*A long table was located near the windows 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. -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. (continued on 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 B. Wing	02/16/2023

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-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.