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	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Healthcare Center	611 East 2nd Ave Flandreau, SD 57028

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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 - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50015 Based on South Dakota Department of Health (SD DOH) complaint intake report, SD DOH facility reported incident (FRI) report, record review, interview, job description and policy review, the provider failed to ensure a thorough investigation was completed for one of one sampled resident (1) identified at risk for elopement who eloped (left the facility without staff knowledge), was found and returned to the facility by staff. Findings include: 1. Review of the 10/11/24 SD DOH complaint intake report revealed: *Resident 1 had eloped. Staff found him approximately a half mile away and returned him to the facility. *Resident 1 has since moved to another facility. *The provider had completed a SD DOH FRI report. 2. Review of the provider's 7/17/24 SD DOH FRI report revealed: *Resident 1 was found in a wheelchair by staff at 12:10 p.m. on 7/17/24 on sidewalk outside facility. *Charge nurse was notified of elopement. *His vital signs were taken and were within normal limits. *Resident 1 stated he wanted to go home. *His Brief Interview for Mental Status (BIMS)assessment score was 10, which indicated he had moderate cognitive impairment. *Resident 1 had a Wanderguard [wearable door alarming device] that was functioning and in place. -His wanderguard monitoring was completed every shift. *When the alarm sounded staff investigated and found a wheelchair transit driver returning another resident from an appointment. (continued on next page)

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.

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

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F 0610 Level of Harm - Actual harm Residents Affected - Few	*On 7/13/24 orders administration note, Resident on first floor this am, trying to get out the doors, was easily redirected. *He was an active exit seeker. *On 1/11/24 order for Wanderguard on wheelchair, monitor placement and functionality q shift. *His family was looking for a secured memory unit to transfer him to. *He was discharged on [DATE] to a memory care assisted living facility. 4. Interview on 10/30/24 at 9:24 a.m. with physical therapy assistant F revealed: *It was reported the following morning at a staff round-up meeting that resident 1 had eloped. *It was reported he was on the other side of the block on the back side of the campus. *She was told to return resident 1 to the second floor after his therapy sessions. 5. Interview on 10/30/24 at 10:15 a.m. with certified nursing assistant (CNA) D revealed: *He observed resident 1 walking behind pushing his wheelchair down the street about 3-4 blocks from the building. *He assisted resident 1 into his vehicle and returned him to the facility. *He notified DON B, registered nurse (RN) C and CNA E of the elopement, where he found resident 1 and that he drove him back to the facility. 6. Interview on 10/30/24 at 10:40 a.m. with RN C revealed: *She heard the exit alarm sound. *Resident 1 got out of the building and was walking up up the road pushing his wheelchair. *CNA D brought resident 1 back to the facility in his vehicle. *RN C completed the skin assessment on resident 1. *She notified resident 1's family and Ecare of his elopement. *Resident 1 would exit seek often. 7. Interview on 10/30/24 at 11:19 a.m. with CNA E revealed: *Resident 1 was found by CNA D by the apartments a couple of blocks from the facility. *CNA D put him in his vehicle and drove him and his wheelchair back to the facility. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	*There had been no other elopements since July (2024). 8. Interview on 10/30/24 at 3:20 p.m. with DON B revealed: *The elopement of resident 1 was reported by CNA D who returned him to the building. *She had become DON on July 1, 2024. *This was the first elopement that occurred since she become the DON. *CNA D stated he observed resident 1 pushing his wheelchair on the sidewalk after his break. *A wheelchair transit driver had returned another resident from an appointment. -The driver had put the code in the door to return the resident and that is how resident 1 got out of the building. *She was unaware that there was no sidewalk outside the front of the building. *She had completed the FRI report and submitted it. *She stated I guess I need to do a more thorough job of investigating. *She had heard two different reports from CNA's about the elopement. *Resident 1's family had been trying to find memory care placement for resident 1 since he was admitted . *He had been evaluated by psych and had medication adjustments numerous times. *He exits sought frequently. *He had a Wanderguard band on. *He was identified as an elopement risk. 9. Review of providers October 2009 Director of Nursing Services job description revealed: *Demonstrates an understanding and knowledge of certification laws and requirements, survey requirements and Medicare programs. *Understands the relationships with state and federal regulatory agencies, and works to maintain positive relationships. *Participates with Center ED and other departments directors in development and maintenance of practices and processes that promote infection control, fire safety and hazard reduction. *Other duties as assigned appropriate to the position. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	10. Review of provider's Elopement/Wandering Policy dated May 2024 revealed: *Elopement: The resident/patient exits the Center without staff knowledge or the resident/patient enters an unsafe area without staff knowledge or presence.