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	11/18/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to implement wound treatment orders for one of one sampled resident (1) with blisters on her buttocks and identified at risk for developing pressure ulcers, which resulted in the blisters going untreated for several days and the development of a stage 2 pressure ulcer (skin wound caused by prolonged pressure where the first two layers of skin are damaged, and the area appears as a shallow, open wound or an intact or ruptured blister) on her sacrum (lower back).Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed that she was admitted on [DATE] with diagnoses of sepsis (a life-threatening condition caused by the body's extreme response to an infection), pneumonia (a lung infection), epilepsy (a neurological condition causing seizures), neuromuscular dysfunction of bladder (bladder control problems caused by nerve or muscle signal issues), restlessness and agitation, dysphagia (difficulty swallowing), major depressive disorder, gastrostomy status (having a surgical hole inserted into the stomach for artificial nutrition and hydration), encephalopathy (brain disorder causing confusion, memory loss, or behavior changes), Type 2 Diabetes Mellitus (T2DM) with diabetic neuropathy (a condition involving disruptions in how the body regulates blood sugar, with associated nerve damage), aphagia (brain condition that makes speaking and understanding language difficult), and acute respiratory failure with hypoxia (sudden onset of difficulty breathing with loss of blood oxygen saturation).The resident relied on staff for completion of all activities of daily living and required the use of a full body mechanical lift for transfers. She had a urinary catheter and was incontinent of bowel. She was unable to reposition herself in bed and required the assistance of two staff members to reposition. Resident 1 was nonverbal due to her aphasia. Staff were directed to communicate with her using yes/no questions, as she was able to shake her head for the yes/no questions. Staff were to assess for signs and symptoms of pain using nonverbal cues. The admission nursing assessment completed on 10/8/25 indicated that her skin appearance was warm, dry and intact. No skin wounds were noted on that assessment. She did not have another skin assessment until she returned to the facility on [DATE] following a hospitalization that began on 10/19/25.Her 10/8/25 admission Braden Scale for Predicting Pressure Score Risk score was 11, which indicated she had a high risk for developing pressure ulcers.Her 10/15/25 Braden score was 12, which indicated she had a high risk for developing pressure ulcers.Her care plan included interventions initiated on 10/9/25 related to impairment of skin integrity such as 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, Monitor/document location, size and treatment of skin injury. Report [skin] abnormalities, failure to heal, s/sx [signs and symptoms] of infection, maceration [skin softening and breakdown] etc. to MD [medical doctor]. Her care plan did not include preventative interventions for staff to follow to ensure no skin breakdown occurred, such as regular repositioning to offload pressure or the use of pillows for position support. Registered nurse (RN) L entered a nursing progress note on 10/16/25 that read, Resident sleeping most evening shift. Regular repositioning. Neb [nebulizer] administer[ed].Resident has 2 spots blister to [her] buttocks. E care [eCare, a telemedicine service] notified with orders. Plan The note did not include what the plan was. There was no documentation that indicated the eCare provider orders had been entered or followed.The 10/16/25 eCare provider note read, .During the assessment the nurse also noted 2 small blister like areas to the [resident's] bilateral [both] buttocks. The resident is being repositioned regularly due to permanent bed-riddance. Nurse is requesting orders for Opti Foam [a wound dressing product] to apply to the areas, [to] change every 3 days and PRN [as needed]. Wound nurse to follow up.Plan: .5. For blisters to bilateral buttocks, continue with repositioning and may apply Opti foam to the areas, change every 3 days and as needed if loose or soiled. 6. Follow up with wound nurse on next rounds.There was no documented skin assessment of the resident's blisters. There was no documentation that the nursing management team or the wound nurse had been notified of the resident's blisters. There was no documentation that resident 1's primary care provider or her power of attorney were notified of the resident's blisters.The 10/16/25 orders for the Opti Foam were not entered into resident 1's EMR physician orders, so it is unknown if the orders were followed. There was no documentation to indicate if, or how often, the resident was repositioned to prevent pressure ulcers.The 10/16/25 eCare progress note was scanned into resident 1's EMR without having been noted by a nurse, meaning that there was no signature of who received the order, entered the order into the resident's EMR, and scanned that document into the resident's EMR.Resident 1 was experiencing a fever

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, interview, observation, and record review, the provider failed to ensure that a certified nursing assistant (CNA) (D) used the whirlpool bath chair safety belt while bathing one of one sampled resident (1) who fell out of the bath chair and was sent to the local emergency room for evaluation. This citation is considered past noncompliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's final FRI received by the SD DOH on 10/20/25 revealed that on 10/9/25, resident 1 was scheduled for a bath and was assisted to the whirlpool tub chair using the full-body mechanical lift. CNA D and another CNA assisted resident 1 into the bath chair. CNA D brought resident 1 in the bath chair to the whirlpool bathtub and gave the resident a bath. After the bath and while still sitting in the bath chair, CNA D wheeled resident 1 out and away from the whirlpool tub, and resident 1 slid out of the bath chair and onto the floor next to the whirlpool tub. She landed on her left side.CNA D called for help and registered nurse (RN) P arrived to assess the resident for injuries. Resident 1 was nonverbal at baseline and would usually respond to staff questions with mumbled speech and moaning. When resident 1 was asked if she was in pain, resident 1 responded with a moan. RN P did not note any physical injuries or bruising at that time.Resident 1's primary care provider was notified, who ordered that resident 1 be transferred to the local emergency room (ER) for further evaluation. Reports from the local ER indicated she did not sustain any acute injuries.CNA D confirmed that she had not used the bath chair safety belt when she gave resident 1 a bath. Upon further investigation, it was determined that the incident resulted from improper use of equipment while providing resident care.Resident 1 admitted to the nursing home the day prior on 10/8/25. Her baseline care plan included she was totally dependent on staff with assistance for transfers and bed mobility which required a minimum of two staff persons.Immediate interventions the provider implemented included: 1) Head to toe skin assessment. 2) Pain Assessment. 3) Neurological assessment. 4) [Medical doctor] and Resident Family updated. 5) Transfer to ER for further evaluation. 6) Care Plans reviewed and updated. 7) [CNA D] suspended pending further investigation. 8) [Local sheriff department] notified. 9) Dakota At Home [Adult Protective Services] notified. 10) Staff in-service/education of Transfers via total body mechanical lift initiated and ongoing. 11) Staff in-service/education on whirlpool tub baths for [residents] that require total dependence initiated and ongoing.Final interventions (to add to initial interventions) [12]. Staff education and in-servicing on appropriate use of Shower chair seat belt and chest belt (if applicable) initiated and ongoing. [13]. [CNA D's employment was] terminated and [is] no longer employed [at the facility]. [14]. Bathing audits to be done twice weekly to ensure appropriate use of Shower chair seat belt/retaining belt with residents during tub baths.2. Review of resident 1's electronic medical record (EMR) revealed that she was admitted on [DATE] with pertinent diagnoses of sepsis (a life-threatening condition caused by the body's extreme response to an infection), pneumonia (a lung infection), epilepsy (a neurological condition causing seizures), neuromuscular dysfunction of bladder (bladder control problems caused by nerve or muscle signal issues), restlessness and agitation, dysphagia (difficulty swallowing), major depressive disorder, gastrostomy status (having a surgical hole inserted into the stomach for artificial nutrition and hydration), encephalopathy (brain disorder causing confusion, memory loss, or behavior changes), Type 2 Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar), with diabetic neuropathy (associated nerve damage), aphagia (brain condition that makes speaking and understanding language difficult), and acute respiratory failure with hypoxia (sudden onset of difficulty breathing with loss of blood oxygen saturation).Her baseline care plan was initiated on 10/9/25 and included interventions to have two staff members assist her with transferring. The bathing portion of her care plan was not added until 10/20/25 and indicated: BATHING/SHOWERING PREFERENCES: TYPE: bed bath. FREQUENCY: 1-2x/week [one to two times per week] and PRN [as needed], that intervention was revised on 11/6/25. An intervention under the falls section of the care plan indicated, Provide 2 person [2 staff members'] assistance with transfers; assist in placement of shower chair waist belt for safety during showers/baths when using the bath chair. Staff may give bed baths for safety related to my contractures and bowed legs. That was initiated on 10/9/25 and revised on 11/6/25.Resident 1 was transferred to the local ER on [DATE] after she fell out of the bath chair. Review of the hospital ER documentation revealed no acute injuries to her head, neck, or shoulder related to the fall. She did not sustain any reddened or bruised areas after the fall.3. Observation on 11/17/25 at 1:17 p.m. in