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	01/28/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), SD DOH complaint records, interview, and policy review, the provider failed to report a FRI and results of their final investigation to the SD DOH within the required time frame regarding nine of nine residents (1, 6, 7, 8, 9, 10, 11, and 12) who had a reportable incident. Findings include:1. Interview and review of the SD DOH FRI (a required reporting of unexpected or adverse events) reports and 1/22/26 SD DOH complaints records with administrator A and director of nursing (DON) B on 1/28/26 at 6:51 p.m. revealed: *Resident 1 reported an allegation of abuse on 1/3/26 at 6:00 p.m. -The initial report was submitted on 1/14/26 at 9:45 a.m. -The final investigation report was submitted on 1/16/25. -The complaints record stated, The facility failed to ensure timely reporting for Resident [1]. Review of reporting records showed the initial report was not submitted until 1/14/26, approximately 11 days after the event occurred. Additionally, while a final report was submitted on 1/16/26, the initial reporting delay failed to ensure immediate protection and oversight. -Administrator A and DON B verified that the initial and final FRI reports regarding resident 1's incident on 1/3/26 were not reported or submitted to the SD DOH within the required time frame. -Administrator A submitted those FRI reports and indicated the initial report was denied and resubmitted on 1/14/26. She could not identify a specific reason why it was not completed within the required time frame. She indicated that she was aware of the SD DOH required reporting time frames and was responsible for doing so. *Resident 6 had a fall that required further medical evaluation for a head laceration needing staples on 12/28/25 at 9:45 p.m. -The initial report was made 12/28/26 at 9:45 p.m. -The final report was submitted 1/20/26 at 3:25 p.m. -The SD DOH complaints record stated, The facility failed to ensure timely reporting of an alleged violation involving Resident [6]. Review of the incident report showed the event occurred on 12/28/25 at 2145 [9:45 p.m.]; however, the initial report was not submitted until 12/29/25 at 2037 [8:37 (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m.], exceeding the required 2-hour reporting timeframe. Additionally, review of reporting records showed the final investigation report was not received until 1/20/26 at 1525 [3:25 p.m.], which exceeded the required 5 working-day timeframe. This failure placed the resident at risk for unaddressed abuse or neglect. -Administrator A and DON B verified that the initial and final FRI reports regarding resident 6's event on 12/28/25 at 9:45 p.m. were not reported or submitted to the SD DOH within the required time frame. -Administrator A submitted those reports and was unsure why it was not completed in the required time frame. *Resident 6 had a fall that required further medical evaluation for a head laceration on 1/4/26 at 2:28 p.m. -The initial report was submitted on 1/4/26 at 3:29 p.m. -There was no final investigation report submitted. -The SD DOH complaints record stated, The facility submitted the initial report for Resident [6] on 1/4/26 at 1529 [3:29 p.m.], meeting the required 2-hour timeframe. However, review of records confirmed no final investigation report was ever submitted. The facility failed to comply with 483.12(c)(4) requirements for reporting investigation results. -Administrator A and DON B verified the FRI regarding resident 6 on 1/4/26 did not have a final investigation report submitted to the SD DOH. -DON B submitted the initial report and was not sure why the final report was not submitted to the SD DOH. *Resident 7 had a fall that required further medical evaluation for head and pelvic pain on 10/13/25 at 4:18 p.m. -The initial report was submitted 10/13/25 at 6:20 p.m. -There was no final investigation report submitted. -The SD DOH complaints record stated, The facility failed to submit the results of an investigation for Resident [7]. While the initial report was submitted timely, the [SD DOH] State Survey Agency rejected the initial report on 11/19/25 and again on 1/20/26, requesting submission of a final investigation report. Review of records confirmed no final report was ever submitted. The facility failed to report investigation results within 5 working days as required. -Administrator A and DON B verified the FRI regarding resident 7 on 10/13/25 did not have a final investigation report submitted to the SD DOH. -DON B submitted the initial report and stated the final investigation report did not get submitted because it got stuck in the cracks. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* Resident 8 had a fall that required further medical evaluation for a head laceration and received a steri-strip (laceration closing dressing) to close the laceration on 11/5/25 at 8:55 p.m. -The initial report was submitted 11/6/25 at 1:41 p.m. -There was no final investigation report submitted. -The SD DOH complaints record stated, The facility failed to ensure timely reporting for Resident [8]. Review of reporting records showed the initial report was not submitted until 11/6/25 at 1341 [1:41 p.m.], exceeding the required 2-hour timeframe. Additionally, the report was rejected on 11/19/25 and again on 1/20/26 with requests for submission of a final investigation report. No final report was received. The facility failed to comply with both initial reporting and investigation reporting requirements. -Administrator A and DON B verified the FRI regarding resident 8 on 11/5/25 was not reported in the required time frame, and the final investigation report was not submitted to the SD DOH. -DON B submitted the initial report. She said she was not aware of the incident until after the required time frame to report it and stated the final investigation report did not get submitted because it got stuck in the cracks. *Resident 9 had a fall that required further medical evaluation due to having a seizure (a sudden, temporary abnormal brain activity) on 11/16/25 at 7:30 p.m. -The initial report was submitted on 11/17/25 at 7:11 p.m. -There was no final report submitted. -The SD DOH complaints record stated, The facility failed to report an alleged violation involving Resident [9] in a timely manner. Review of records showed the initial report was not received until 11/17/25 at 1911 [7:11 p.m.].exceeding required reporting timeframes. Additionally, no final investigation report was ever submitted. The facility failed to ensure timely reporting and completion of the investigation process. -Administrator A and DON B verified the FRI regarding resident 9 on 11/16/25 was not reported in the required amount of time, and no final investigation report was submitted to the SD DOH. -DON B submitted the initial report and did not recall why it was not submitted in the required time frame or why the final investigation report was not done. *Resident 10 had a fall that required further medical evaluation due to hitting her head and having a seizure on 12/5/26 at 9:05 p.m. -The initial report was submitted on 12/6/25 at 12:12 p.m. -The final investigation report was submitted on 12/15/25. -The SD DOH complaints record stated, The facility failed to ensure timely reporting for Resident [10]. Review of reporting records showed the initial report was submitted on 12/6/25 at 1212 [12:12 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m.], exceeding the required 2-hour reporting timeframe. Additionally, the final investigation report was submitted on 12/15/25, exceeding the required 5 working-day timeframe. The facility failed to comply with both reporting requirements. -Administrator A and DON B verified that the initial and final FRI reports regarding resident 10 on 12/5/25 were not submitted within the required time frame to the SD DOH. -Administrator A submitted those reports and was unsure why they were not completed within the required time frame. *Resident 11 had a fall that required further medical evaluation due to a left arm fracture on 12/17/25 at 5:30 a.m. -The initial report was submitted on 12/17/25 at 9:30 p.m., per the FRI report. -There was no final report submitted. -The SD DOH complaints record stated, The facility failed to ensure timely reporting for Resident [11]. Review of the incident report showed inconsistent event dates listed as 12/17/25 and 12/24/25. The initial report was not received until 12/29/25 at 2129 [9:29 p.m.], which exceeded the required reporting timeframe regardless of the event date. Additionally, no final investigation report was submitted. The facility failed to ensure accurate documentation and timely reporting. -Administrator A and DON B verified the FRI regarding resident 11 was on 12/17/25 and that it was not submitted in the required time frame, and no final investigation report was submitted to the SD DOH. -Administrator A submitted the initial report and was not sure why the initial report was not submitted in the required time frame and was not sure why the final investigation was not completed. *Resident 12 had an alleged potential resident-to-resident physical abuse on 11/21/26 at 7:00 a.m. -The initial report was submitted on 11/22/25 at 3:00 a.m. -There was no final investigation report submitted. -The SD DOH complaints record stated, The facility submitted the initial report for Resident [12] on 11/22/25 at 0300 [3:00 a.m.], which met the required 24-hour reporting timeframe. However, review of records confirmed the facility never submitted a final investigation report. The facility failed to report investigation results within 5 working days as required. -Administrator A and DON B verified the FRI regarding resident 12 on 11/21/25 did not have a final investigation report submitted to the SD DOH. -Administrator A submitted the initial report, and she recalled doing the investigation, but was unsure why the final investigation report was not submitted to the SD DOH. 2. Interview on 1/27/26 4:44 p.m. and on 1/28/26 at 4:37 p.m. with administrator A revealed: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She started working at the facility on 11/10/26. *She acknowledged the facility had issues with reporting FRIs to the SD DOH. *Incidents that required reporting to the SD DOH were abuse/neglect, falls with injury, medication errors, falls with unknown origin, allegations, and missing medications. -Allegations, falls of unknown origin, and falls with major injury were to be reported to the SD DOH within two hours. -All other incidents needed to be reported to the SD DOH within 24 hours. -The final investigation report needed to be submitted to the SD DOH within five days. *All managers had completed their education regarding incidents that needed to be reported to the SD DOH. *She and DON B were responsible for completing reports to the SD DOH. Staff were to call her or DON B, even in the middle of the night, to be informed of any resident's incidents so they could determine if they needed to be submitted to the SD DOH. *Administrator A and DON B put a reminder on a shared calendar to remind them when a final investigation report needed to be submitted to the SD DOH. *Around 50% (percent) of the staff had completed the all-staff education regarding resident reportable events, and they still had a few days to complete it by the deadline they had given. *She completed her education regarding reporting to the SD DOH. 3. Interview on 1/27/26 at 5:44 p.m. with social services director C revealed that administrator A or DON B were responsible for completing the initial and final FRI reports to the SD DOH. 4. Review of the provider's October 202[?] Abuse Reporting and Response policy revealed: * The Center immediately reports all suspected and/or allegations of abuse, neglect, and exploitation of residents, misappropriation of resident property, mistreatment, and injuries of unknown source in accordance with state and federal law. *Staff immediately reports all alleged or suspected violations to the supervisor and Executive Director. *The Executive Director or designee reports alleged violations to the state survey agency and other officials in accordance with state law.as follows: -immediately but not later than 2 hours-All allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, if the events that cause the allegation involve abuse or result in serious bodily injury. -**Note-reporting requirements are based on real clock time, not business hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The Center reports the results of all investigations to the Executive Director and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident. *The Center identifies staff responsible for implementation of corrective actions, expected date of implementation, and those responsible for monitoring. *Additional training is conducted with staff, and staff competency is evaluated as necessary. *Failure to report suspicion or allegations of abuse timely by staff will result in disciplinary action up to and including termination.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of the provider's South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, observation, and policy review, the provider failed to ensure one of one resident (1) who reported an abuse allegation towards a certified nursing assistant (CNA) K, was reported within the required time frame. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include:1. Review of the initial 1/14/26 SD DOH FRI dated revealed:*Resident 1 had an abuse allegation involving CNA K on 1/3/26 at 6:00 p.m. *Resident 1 alleged that during the provision of care, CNA K verbally assaulted him, slapped him, and pushed him into his bed.*Upon the allegation being reported to the CNA J on 1/6/26.*Interviews were conducted with resident 1 and the staff members involved in the incident.*Resident 1 was assessed with no signs or symptoms of injury. *Resident 1's family, physician, and local police department.*A full investigation was in process, and a final report was to be submitted upon completion of the investigation. *CNA K was suspended pending the outcome of the investigation. 2. Review of resident 1's electronic medical record (EMR) revealed:*He had a Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. *He had a scheduled skin assessment completed on 1/5/26. There were no observations of bruising or finger marks documented.*His 1/15/26 care plan stated Has a history of making accusatory statements of non-Caucasian staff, (will take all statements serious and follow proper policy/procedures for investigation). I would prefer to have Caucasian staff care for me when able. I am aware this might not happen at all times. 3. Interview on 1/27/26 at 3:51 p.m. with certified nursing assistant (CNA) G, revealed:* Resident 1 has had volatile behaviors and was verbally abusive and used malicious slander towards her and other staff when providing care for the resident. 4. Interview with administrator A on 1/27/26 at 4:00 p.m. regarding resident 1's documentation in his electronic medical record (EMR) revealed:*On 1/9/26, an in-person interview with resident 1 and the counselor from Deer Oaks Psychological Services was conducted. During the interview, resident 1 reported that CNA K became physical with him during his evening cares on 1/3/26.*Resident 1 verbalized to the counselor that he had a sense of safety in the care setting, denying that others make him feel intimidated. 5. Interview on 1/27/26 at 5:44 p.m. with social services director (SSD) C revealed that administrator A or DON B was responsible for completing the initial and final FRI reports to the SD DOH. 6. Interview on 1/28/26 at 1:19 p.m. with licensed practical nurse (LPN) /care coordinator (CC) E revealed that while checking on resident 1 on the morning of 1/8/26, the resident indicated that over the weekend, a black lady CNA K pushed him down on his bed while she assisted him with his care needs. 7. Interview and observation on 1/28/25 at 4:37 p.m. with administrator A revealed:*She stated she should have followed up with resident 1 on 1/5/26 when he had reported the incident from 1/3/26, instead of waiting until 1/6/26.*CNA K worked two shifts during the period from 1/3/26 through 1/9/26. She did not provide care for resident 1 during those scheduled shifts.*CNA K was suspended on 1/9/26 for a total of 2 hours during the investigation and then was allowed to return to work the evening of 1/9/26.*CNA K does not provide care for resident 1 per the resident's choice.*Administrator A stated that CNA K was ill and unable to speak due to not having a voice. *Administrator A attempted to contact CNA K multiple times for an interview on 1/27/26 and 1/28/26, but was unsuccessful. 8. Interview on 1/28/26 at 11:55 a.m. with social services director (SSD) C revealed:*On the morning of 1/5/26, CNA J informed her that resident 1 complained of being physically abused by CNA K to CNA J on 1/3/26 during his bath.*SSD reported resident 1's complaint to the scheduled interdisciplinary team (IDT) meeting on 1//5/26, which was held right after she had been informed of the complaint.*She indicated that after she reported it, it was to be handled (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by administrator A.*She stated that resident 1 has had concerns with staff of different races providing his care. 9. Interview on 1/28/26 at 12:19 p.m. with CNA J revealed:*On 1/5/26, during resident 1's bath, he complained of being physically abused by CNA K on 1/3/26.*CNA J reported resident 1's complaint to SSD C after his morning bath on 1/5/26. 10. Interview on 1/28/26 at 4:05 p.m. with resident 1 revealed:*On Saturday (1/3/26), CNA K had physically abused him when she provided his care needs.*He stated, She choked me, pushed me down on the bed, and slapped me. She does not care for me; I will not let her in my room. 11. Review of the provider's September 2017 Abuse Reporting and Response policy revealed:* The Center immediately reports all suspected and/or allegations of abuse, neglect, and exploitation of residents, misappropriation of resident property, mistreatment, and injuries of unknown source in accordance with state and federal law.* Staff immediately reports all alleged or suspected violations to the supervisor and Executive Director.* The Executive Director or designee reports alleged violations to the state survey agency and other officials in accordance with state law.as follows:-immediately but not later than 2 hours-All allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, if the events that cause the allegation involve abuse or result in serious bodily injury.-**Note-reporting requirements are based on real clock time, not business hours.* The Center reports the results of all investigations to the Executive Director and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident.* The Center identifies staff responsible for implementation of corrective actions, expected date of implementation, and those responsible for monitoring.* Additional training is conducted with staff, and staff competency is evaluated as necessary.* Failure to report suspicion or allegations of abuse timely by staff will result in disciplinary action up to and including termination.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the provider failed to ensure care services were provided for:*One of one resident (4) who had pain with urination, a temperature, and physician's orders to collect a urine sample on 1/12/26, which was not collected by the provider, and may have delayed treatment.*One of one resident (5) who had black stools, strong-smelling urine, and physician's orders to collect lab work on 1/9/26, which was not collected until 1/14/26, and may have delayed treatment. Findings include:1. Interview on 1/28/26 at 2:20 p.m. with resident 4 in his room revealed:*He had his urine tested in Sioux Falls, he was unsure when, but it had been negative, but he continued to have burning with urination. 2. Review resident 4's paper and electronic medical record (EMR) revealed:*He was admitted to the facility on [DATE].*He had diagnoses of alcoholic cirrhosis of the liver with ascites (extensive scarring and fluid buildup caused by long-term alcohol use) and acute kidney failure (sudden decline in kidney function).*His 12/10/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated his cognition was intact.*A 1/12/26 at 2:57 p.m. physician's order stated, Please collect a UA [urine analysis] sample and bring to clinic today.*A nursing progress note on 1/12/26 at 4:56 p.m. written by licensed practical nurse (LPN) L stated, Resident c/o [complained of] painful urination and increased frequency and urgency. Resident [4] describes pain as being sharp and only when he attempts to urinate. No pain over bladder upon palpation. Resident [4] states he drank about half of his water mug which equals to be approximately 450 cc of water.-Vital signs obtained [were] BP [blood pressure]-118/72, P [pulse]-103, R [respirations]-18, T [temperature]-101.1 O2 [oxygen]-95%, P [pain]-10/10.-Resident [was] informed that [the] provider [doctor] will see him tomorrow 1/13/26 during Doctor rounds. Family informed of this as well.* A nursing progress note on 1/13/26 at 12:28 p.m. written by registered nurse (RN) M stated, Staff reporting temp of 102 and Dr. [resident 4's primary care provider (PCP)] requests he be seen at [the] clinic today for further evlauaution [evaluation] and to postpone upcoming GI [gastrointestinal] testing scheduled for 1-14-26.Clinic app't [appointment] made for 3:15pm and resident informed.*A late entry nursing progress note created on 1/15/26 at 5:20 p.m. for 1/13/26 written by LPN/care coordinator (CC) E stated, [Resident 4's PCP] here for in-house rounds and recommended resident be seen in the clinic d/t [due to] fever and nausea.*A 1/13/26 at 3:19 p.m. family medicine visit report indicated the resident had urinary retention (unable or difficulty urinating). They completed a bladder scan and which revealed 906 cc (cubic centimeters) of urine was in his bladder. They inserted a Foley catheter, obtained a urine sample, administered IV antibiotics, and would start oral antibiotics the next day for a suspected UTI.*A 1/13/26 physician's order that stated, RSV [respiratory syncytial virus]/COVID/Influenza swabs collected; Also strep swab. All swabs negative. UA ordered. Foley catheter [flexible tubing placed in the bladder to drain urine]. Catheter cares BID [twice a day]. Can attempt to discontinue foley 1/15. IV [intravenous] Rocephin [antibiotic] administered for suspected UTI [urinary tract infection]. Cipro 250 mg [oral antibiotic] BID ordered to started [start on] 1/14/26. Diagnosis: UTI *A nursing progress note on 1/13/26 at 5:46 p.m. by RN D stated, Sister was informed [that] resident [4] remain [remained] @ [at] ER [emergency room] all test [tests] are negative . COVID RSV etc [etcetera]. On IV antibiotics now, back @ the manor [facility] in an hour.*A nursing progress note on 1/13/26 at 6:21 p.m. written by RN D stated, Resident returned per RHCC [facility] van. With orders. RSV/COVID /Influenza swabs collected. Also strep swabs All negative. UA ordered. Foley placed . catheter cares BID. Can attempt to discontinue Foley 1/15. IV Rocephin administered- for suspected UTI. Cipro 250 mg BID ordered start 1/14/26 [period] 3. Interview on 1/28/26 at 5:15 p.m. with director of nursing (DON) B (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed:*There was no documentation of what information was sent to resident 4's physician before the UA order was received on 1/12/26 at 2:57 p.m. *She indicated that resident 4's UA should have been collected on 1/12/26 as ordered by the physician, and verified that not doing so may have caused a delay in treatment. 4. Interview on 1/28/26 at 5:53 p.m. with LPN/CC F revealed:*She was not sure what notification the physician received that prompted the order for the UA on 1/12/26.*The UA should have been collected on 1/12/26 as ordered by his physician.*On 1/13/26, the physician requested that resident 4 to be seen in the clinic that same day, and a UA was collected at the clinic on 1/13/26 at 4:36 p.m.*The UA was not cultured because that was not indicated per the test results.*The physician treated him with antibiotics due to his elevated temperature and symptoms. 5. Interview on 1/28/26 at 2:25 p.m. with resident 5 in her room revealed:*She felt like she was able to see a doctor if she needed to and felt the staff completed physician order lab work in a timely manner. 6. Review of resident 5's paper and EMR revealed:*She was admitted to the facility on [DATE].*She had a diagnosis of intracerebral hemorrhage (bleeding in the brain).*Her 11/26/25 BIMS assessment score was 11, which indicated her cognition was moderately intact.*On 1/8/26 a fax was sent to the resident 5's physician that stated, Staff reports dark black stool x [for] 2 days. In addition, her urine has a strong odor. Please advise.*An undated physician's order stated, she [resident 5] is on iron supplements, which can cause dark stools versus GI bleed-she should have labs done check CBC [complete blood count] and CMP [complete metabolic panel] today as well as a UA.-The physician's order was acknowledged as received by staff on 1/13/26, but the time was not documented.*On 1/9/26 at 1:10 p.m. resident 5's physician sent an email with a document attached to it to LPN/CC F and requested a status update on resident 5. LPN/CC F responded by email on 1/9/26 at 1:16 p.m. that her vital signs were stable, resident 5 stated she felt fine, and staff had no further information to report.*A progress note on 1/13/26 at 9:03 a.m. written by RN N stated, Resident [5] had dark stools and strong urine odor, [provider name] CNP [certified nurse practitioner] , gave order to collect CBC and CMP and a UA today.*A progress note on 1/14/26 at 1:13 a.m. written by LPN O indicated the day and evening shift did not obtain a urine sample, and the resident was asleep. The urine sample was rescheduled to be collected when she was awake.*On 1/14/26 at 1:27 p.m. LPN/CC F sent an email to resident 5's physician which stated, When you get a chance would you look at the labs from this am [period] Resident 5's physician responded at 2:40 p.m. that her labs were okay. LPN/CC F informed the physician that they were waiting on a UA sample from resident 5 due to her being unable to urinate and did not want a catheter placed. The physician stated they did not need to collect a UA unless resident 5 had symptoms other than odor.*There was a CMP lab report collected on 1/14/26 at 8:15 a.m.*There was no CBC report to review.*There was a progress note on 1/14/26 at 2:37 p.m. written by LPN/CC F that indicated resident 5's CMC and CMP were collected, and the clinic obtained the CMP. 7. Interview on 1/28/26 at 5:15 p.m. with DON B revealed:*She was not sure when the order for the labs was received.*She expected the labs to be collected on the day the order was received from the physician, if it was during lab business hours. 8. Interview on 1/28/26 at 5:53 pm. with LPN/CC F revealed:*The document that was attached to the physician's email received on 1/9/26 at 1:10 p.m. was the order for resident 5's CBC, CMP, and UA labs.*She left the facility before then on 1/9/26 so she did not receive that email.*She stated that the physician's order was faxed to the facility on 1/9/26 and was not acknowledged by staff until 1/13/26.* She collected resident 5's CBC and CMP on 1/13/26 at 11:31 a.m. The CMP needed to be recollected by the lab the next morning because the sample was unable to be tested.*Resident 5's CMP, CBC, and UA lab specimens should have been collected on 1/9/26 when the physician's order was received.*The labs, including the UA should have been collected on 1/9/26 when the order was (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	01/28/2026

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received. 9. Interview on 1/28/26 at 2:45 p.m. with LPN/CC F revealed:*She felt if a resident needed to be seen by a physician, the clinic typically scheduled them an appointment in a timely manner.*Physician rounds at the nursing home were done twice a month. Once by the doctor and once by the CNP.*Physicians orders were to be entered into the residents EMR during the same shift that they were received in.*Lab work could be done at the nursing home and taken to the lab at the clinic/hospital.-The lab was open Monday through Friday until 5:00 p.m. and on Saturdays until 12:00 p.m.-If emergent, lab work could be dropped off at any time because the clinic/hospital had a lab technician on call.*The physicians were notified of residents' health concerns, and orders were received by email or by fax. 10. Interview on 1/28/26 at 2:50 p.m. with RN D revealed physician's orders were to be processed immediately. 11. Review of the provider's April 2024 Physician Orders policy revealed:* Physician orders are reviewed and revised daily, via the Electronic Health Record [EHR].* The licensed nursing staff is responsible for inputting admission, telephone and verbal physician's orders into the EHR immediately upon receipt from the provider.* The Director of Nursing establishes the licensed clinician responsible for recap and reconciliation of New, Discontinued, or Completed orders in the EHR daily and initiates corrections daily.