

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Riverview Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, observation, and policy review, the provider failed to ensure two of two registered nurses (RNs) (D and J) had access to the emergency medication kit (e-kit) for one of one sampled resident (1) who subsequently did not receive his antipsychotic medication (a drug that alters specific brain activities to reduce symptoms of mental health conditions) and hallucinated and started a fire in his bedroom. Certified nursing assistant (CNA) K and RN J extinguished the fire, and no residents were injured as a result of the fire. Findings include: 1. Review of the provider's 5/27/26 SD DOH FRI revealed that at approximately 5:00 a.m. on 5/27/26, staff found resident 1 in his room with a lighter after a small fire ignited and damaged a plastic water mug, part of his mattress, and his bed linens. Resident 2, resident 1's roommate, had alerted the staff, who quickly extinguished the fire with water and evacuated nearby residents until the fire department cleared the area. Emergency medical services (EMS) assessed both residents. Resident 1 was evaluated at the clinic and admitted to the hospital for observation, while his roommate declined further evaluation. Resident 1's family was notified, the lighter was removed, and his care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) was reevaluated upon his return to the facility. 2. Review of resident 1's electronic medical record (EMR) revealed that he admitted to the facility from the hospital on 5/26/26. His 5/26/26 hospital referral packet indicated resident 1 was treated for delirium (sudden, severe confusion with trouble focusing and awareness). His doctor prescribed 2.5 milligrams (mg) of olanzapine, an antipsychotic medication, in the morning, and 7.5 mg of olanzapine at bedtime to treat his delirium. On 5/26/26, he received his morning dose of olanzapine at 7:35 a.m. at the hospital before he discharged from the hospital to the nursing facility. His 5/26/26 hospital discharge orders indicated he was to continue taking the morning and bedtime doses of olanzapine. A note categorized as Orders - Administration Note was entered on 5/26/26 at 9:34 p.m. that read, New admit awaiting meds. Throughout the night on 5/26/26 and into the early morning of 5/27/26, resident 1 was attempting to get out of bed by himself. He was given 2 mg of lorazepam (a medication used to treat anxiety), at around 12:10 a.m. on 5/27/26. A nursing progress note from 5/27/26 at 2:06 a.m. read, [resident 1] was found with bed pushed away from the wall and was attempting to climb out of bed. CNA's [Certified nursing assistants] assisted resident back into bed. The lorazepam medication was entered on 5/27/26 at 6:41 a.m. that read, Resident's son [was] made aware of fire started this [morning] by resident. Let him know EMS [emergency medical service] checked him over and that there were reports of hallucinations at the time. [Resident 1's son] stated that he was having those [hallucinations] in the hospital as well. A nursing progress note written by contracted travel RN J on 5/27/26 at 7:09 a.m. read, At [5:00 a.m.], This nurse heard CNA yelling down [the] hallway. This nurse went down [the] hallway and walked into [the] resident's room to find soaker pad [an incontinence product, relating to involuntary urine or bowel leakage] and [bed] sheet on the floor on fire. As well as [the] mattress on fire with [resident 1] sitting near it. CNA grabbed [roommate's] (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	water jug and dumped it on the bed. This nurse put out sheets on the floor. Room was filled with smoke. Got resident in his] wheelchair and out of [the] room. RN J assessed resident 1 and did not find any skin injuries or burns.A nursing progress note written by contracted travel RN J on 5/27/26 at 7:36 a.m. read, Called [telehealth, an electronic remote health service] to get a [one-time] dose for olanzapine [7.5 mg] instead of the [2.5 mg] due to [the] resident missing [a] dose last night due to pharmacy not bringing [the olanzapine].3. Interview on 6/1/26 at 11:42 a.m. with resident 2 revealed that he was resident 1's roommate and witnessed the fire on the morning of 5/27/26. He explained that resident 1 admitted to the facility on the evening of 5/26/26. Resident 2 stated that throughout the night on 5/26/26, resident 1 appeared anxious and verbalized that he wanted to go out to smoke. Resident 2 awoke early in the morning to a noise and saw resident 1 playing in the fire. He yelled for the staff, who came to their room right away and extinguished the fire.4. Interview on 6/1/26 at 2:34 p.m. with resident 1 revealed that he did not remember starting the fire or much from that night. He said, Apparently, I was hostile, but I don't remember. I was pretty mad, mad at the world. I don't know if I was dreaming.5. Review of the police department's report regarding the early morning fire on 5/27/26 revealed, when asked who else was in the room, [resident 1] stated that [four] adult males were also in his room, along with his roommate [resident 2]. [The officer] spoke to [resident 2], who stated that [resident 1] had used the lighter to start a fire. [Resident 2] stated that only [resident 1] and [resident 2] were in the room at the time.At this time, [the officer] cannot determine if the fire was intentional. [Resident 1] appeared to not understand how the fire started, and indicated in his statements about who else was in the room, that he was possibly hallucinating.6. A phone interview with resident 1's family member and responsible party was attempted throughout the survey, but the calls were not answered. There was no ability to leave a voicemail message for a return call, as the family member's phone voicemail box was full.7. Phone interview on 6/2/26 at 7:38 a.m. with contracted travel RN J revealed that resident 1 admitted to the facility late in the evening on 5/26/26 and the pharmacy did not deliver a supply of his bedtime dose of olanzapine to the facility. Olanzapine, both 2.5 mg and 7.5 mg, was available in the emergency medication kit (e-kit), but neither she nor RN D had access to unlock the e-kit. She called the telehealth provider early in the morning on 5/27/26 for an increased dose of resident 1's olanzapine because he hallucinated during the night and started a fire in his bedroom. Another nurse with access to the e-kit was present at that time and obtained the olanzapine from the e-kit and administered it to resident 1. She started working at the facility at the end of March 2026, and director of nursing (DON) B gave her a login username and password to access medications in the e-kit on Friday 5/29/26.8. Interview on 6/2/26 at 3:14 p.m. with contracted travel licensed practical nurse (LPN) I revealed that he started his contract at the facility on 5/25/26. He did not have access to the e-kit until Friday 5/29/26.9. Observation and interview on 6/2/26 at 3:23 p.m. with RN E in the medication room revealed there was a tall gray cart with multiple locked drawers. There was a computer on top of the cart and a fingerprint scanner. She explained that the cart was their e-kit. She believed the contracted travel nurses were not supposed to have access to the e-kit. She confirmed that olanzapine was available in the e-kit in 2.5 mg and 5 mg tablets.10. Interview on 6/2/26 at 3:45 p.m. with administrator A and director of nursing (DON) B revealed that resident 1 was a late admit. He arrived at the nursing home between 4:00 and 5:00 p.m. on 5/26/26. When residents admitted to the nursing home from the hospital, their medication orders were to be faxed to the pharmacy. Social services assistant (SSA) C was responsible for faxing the residents' medication orders to the pharmacy. If a resident was scheduled to receive a medication that was not delivered to the facility yet, DON B expected the nurses to obtain that medication from the e-kit to administer to the resident. She expected the nurses to call a nurse manager if they did not have access to the e-kit. DON B said that LPN G would have been available to go to the facility to unlock the e-kit for RNs D and J.Administrator A and DON B identified that not all licensed nurses had access to the e-kit after resident 1's fire-starting incident on the morning of 5/27/26. At that time, DON B did not have the capability to grant other nurses access to the e-kit. Once administrator A and (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON B contacted the corporate office and DON B gained that capability, DON B started granting access to the e-kit to all licensed nurses on staff on 5/29/26.11. Review of the provider's e-kit instruction manual revealed that a person with an administrator's account had to log into their profile to add new employees to the system to grant access to the e-kit.12. Review of the provider's January 2025 Emergency Pharmacy and Emergency Kits (E-Kits) policy revealed that emergency needs for medication are met by using the nursing care center's approved emergency medication supply or by special order from the provider pharmacy. When an emergency or stat [immediate] medication is needed, the nurse first verifies and reviews the prescriber's orders for appropriateness, checks the resident's allergies, and removes the required non-controlled medication from the emergency kit. Emergency medications are only administered with a valid prescriber's order.13. Review of the provider's November 2016 admission policy revealed the policy did not contain instructions or guidance related to the process of receiving new resident physicians' orders or obtaining a resident's medications before admitting to the facility.		