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	02/27/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46453 Based on observation, interview, and policy review, the provider failed to maintain a homelike environment that was free from major damages to the walls, floors, ceilings, and door frames. Findings include: 1. Observation on 2/25/25 at 9:48 a.m. of the bathroom shared by residents 6, 9, and 34 revealed: *The ceiling consisted of bare chicken-wire-type metal sheeting. *There was plaster stuck to parts of the chicken wire. *A portion of the chicken wire had been partially cut out from the rest. It was hanging down and was attached by five pieces of wire twisted around it. The pieces of wire looked like bread bag twist ties. *The piece of chicken wire that was hanging down was directly above the toilet. -If a person were sitting on the toilet and the piece of chicken wire fell , it would have landed on top of that person. *Interview at that time with resident 9 revealed that ceiling had been like that for quite some time, but she could not remember exactly how long. 2. Observations throughout the building on 2/26/25 from 9:04 a.m. to 9:25 a.m. revealed: *The door frame of an emergency exit door was rusted and corroded away at the bottom. -Expanding foam insulation had been sprayed into that corroded area. -Rusty, jagged edges were exposed. *There was no baseboard around the perimeter of a storage room/toilet room on the second floor. What appeared to be particle board or corkboard was exposed. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*There were several large paint chunks missing from the walls in the hallway on the second floor. *In the whirlpool tub room on the first floor: -The wallpaper was peeling in several spots. -The caulking around the toilet was stained and had turned brown and black in some areas. -The baseboard heating elements were exposed, potentially causing a hazardous environment. -The floor in the shower had stained to a reddish orange, potentially from rust. *In the therapy gym: -There were several chunks of flooring missing in the main walkway. There was black tape over some of the missing tile pieces. -The rubber mat under one piece of exercise equipment had a large tear, potentially causing a tripping hazard. -There was no light cover over one of the fluorescent light fixtures. It was unknown if those light bulbs were shatter-proof or not. -Interview with physical therapist assistant (PTA) Y at the time of the observation revealed the damage in the floor started over a year ago when the light fixture cover fell from the ceiling and hit the floor. -She indicated the maintenance department was aware of the flooring and light fixture issue. 3. Interview on 2/27/25 at 2:03 p.m. with maintenance director Z revealed: *He was aware of the bathroom ceiling. -There was a leak in the ceiling pipes, and he had to remove the plaster and cut a hole in the chicken wire. -He indicated that a contractor was supposed to have been fixing the ceiling the week of the survey or the next, but they rescheduled due to the survey. *He was aware of the damaged door frame. -He put spray foam in the damaged parts to temporarily minimize the draft that was blowing through. -He had contacted several contractors to fix the door frame but was having difficulties with the various contractors' schedules. -He started contacting contractors to fix the door frame in July 2024. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*He was aware of the lack of a baseboard in the toilet/storage room. -Again, he stated that he was waiting on the contractor to schedule and address the issue. *He was not aware of the peeling and torn wallpaper in the whirlpool tub room. 4. Interview on 2/27/25 at 2:36 p.m. with interim administrator AA revealed: *She was assisting with administrator duties as the new administrator had only been at that facility for about a week. *She was aware of the flooring issues in the therapy room. *A local flooring company recently provided a quote to fix the flooring in several areas of the building, including the therapy room, and she was waiting on the availability of funds for that project. *She was not aware of the issue with the deteriorating door frame but indicated that she knew a contractor that would be able to perform that task. 5. A Homelike Environment policy was requested on 2/27/25. The provider gave their July 2008 Preventative Maintenance policy. Review of that policy revealed: *Policy Statement: .The intent of this program is to establish a building where the environment is safe and comfortable, essential utilities are delivered without interruption and mechanical systems and equipment operate safely, accurately, and reliably. *Procedure: - .2. All areas of the Center and equipment therein, are inspected and maintained in accordance with the scheduled maintenance system (SMS). The Maintenance Department is responsible for the condition and function of the Center's physical plant, including utilities, grounds, and equipment. Each Center customizes the SMS to meet the specific needs of their building. Administrative authorized external service organization may be utilized as part of the SMS for complex systems or to meet code requirements in specific regions or locals.

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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. 50916 Based on observation, interview, record review, and policy review, the provider failed to revise and update a care plan to reflect the current needs for one of one (10) sampled resident with pressure ulcers to his heels and an abrasion to his coccyx. Findings include: 1. Observation and interview on 2/25/25 at 10:50 a.m. with resident 10 in his room revealed: *He was lying in bed and had a breakfast tray on his side table. *He stated he had wanted to stay in bed for breakfast. *He had a catheter and a feet elevation cushion (to keep heels off the bed) which was not positioned correctly, and his heels were touching the bed. Interview on 2/26/25 at 7:27 a.m. with registered nurse (RN) B revealed: *Resident 10 had a stage II pressure ulcer (wound with partial thickness skin tissue loss from prolonged pressure) on each heel. *She had already done the pressure ulcer wound care. Review of resident 10's electronic medical record (EMR) revealed he had: *A stage II pressure ulcer was found on his right heel on 8/26/2024. *A stage II pressure ulcer was found on his left heel on 1/3/2025. *A superficial abrasion to the coccyx (tail bone) was found on 2/25/25. Review of his last updated care plan on 5/30/2024 related to his skin impairment included: *Focus: I have the potential for pressure ulcer development r/t [related to] Hx [history] of ulcers, immobility. *Goal: I will have intact skin, free of redness, blisters or discoloration by/through review date. *Interventions: -Elevate/float heels when in bed to offload pressure as I allow. -Follow facility policies/protocols for the prevention/treatment of skin breakdown. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Frequent repositioning while resting. -Inspect skin while providing cares, notify nurse of any new skin conditions. -Instruct/assist/encourage me to shift weight in W/C [wheelchair] routinely. -Pressure reducing air mattress to bed. -Pressure reducing cushion to wheelchair. *There was no indication in his care plan that he had any pressure ulcers or abrasions on his skin. Interview on 2/27/25 at 12:27 p.m. with director of nursing (DON) A regarding resident 10's care plan revealed: *She was responsible for creating and updating resident care plans. *She agreed resident 10's care plan was not updated to reflect his individualized skin integrity needs and did not include he had pressure ulcers. Review of the provider's January 2025 Skin Integrity policy revealed: *In the event that a resident is admitted with or develops a skin ulcer/pressure ulcer/wound, care is provided to treat, heal, and prevent, if possible, further development of skin ulcers/pressure ulcers/wounds. *1. The nurse completes the Braden Scale/Skin Integrity Evaluation at admission, weekly for three weeks, and then annually. The Braden Scale is a guide to determine risk stratification for skin impairment. -2. The nurse establishes a plan of care based on risk factors in an effort to limit their potential effects. -3. The resident's skin is inspected daily with completion of ADL's [activities of daily living] (unless resident is independent in ADL completion). Changes in the resident's skin are reported to the Licensed Nurse (LN). *If skin impairment is noted after admission, the LN: -c. Implements new interventions as needed. Documents on the resident's care plan and ISP. -e. Notifies Director of Nursing Services (DNS) of skin Impairments that indicate a potential significant change in condition (State II or greater Pressure Ulcer, surgical wound dehiscence, hematoma, or bruise on an area of the body not usually vulnerable to trauma (e.g. head, breasts, inner thighs, groin). The provider did not have a care plan policy.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46453 Based on observation, interview, record review, and policy review, the provider failed to ensure quality of care was provided related to one of one sampled resident's (20) wound care improperly delegated by registered nurse (RN) R to certified nurse assistant (CNA) J, hospice coordination of care for two of two sampled residents (12 and 49), and pain management for one of one sampled resident (49). Findings include: 1. Interview on 2/25/25 at 10:11 a.m. with resident 20 and his wife in their room revealed: *He had a sore on his bottom. *He was supposed to have his wound dressing changed every other day in the evenings. *Both resident 20 and his wife indicated that CNA J had performed the wound dressing change that previous evening. *They indicated that RN R was supposed to have completed the wound dressing change, not CNA J. *They described a specific type of ointment that was placed on the wound. They mentioned the word collagen. Review of resident 20's electronic medical record (EMR) revealed: *His 1/7/25 annual Minimum Data Set assessment indicated a Brief Interview for Mental Status assessment score of 14, which indicated he was cognitively intact. *A 12/18/24 physician's order for Posterior L &R [left and right] Thighs &L buttock Abrasions: Cleanse with wound cleanser, pat dry, apply Moistened Collagen [wound healing product] to wound beds, cover with Optifoam [wound dressing]. As needed for when falls off/after bath. -The treatment administration record (TAR) indicated that order had been last completed on 2/20/25 by RN E. *A 12/18/24 physician's order for Posterior L &R Thighs &L buttock Abrasions: Cleanse with wound cleanser, pat dry, apply Moistened Collagen to wound beds, cover with Optifoam. Every day shift every 2 day(s) for Abrasions until healed. -The TAR indicated that order had last been completed on 2/23/25 by RN B. Interview on 2/26/25 at 4:08 p.m. with RN R revealed: *Wound treatments were usually completed during the day shift. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*Resident 20 sometimes requested a new Optifoam dressing after he used the bathroom. -If he requested a new dressing at night when she was very busy, she would ask the CNA to apply the Optifoam dressing. *The only treatment that she had completed for resident 20 on the evening shift was applying an ointment on his left hip for pain. Interview on 2/26/25 at 4:26 p.m. and 4:35 p.m. with CNA J revealed: *She confirmed that she had applied resident 20's ointment and dressing bandage when the nurse was busy. *She could not remember what type of ointment she applied for resident 20, but she said it was yellow. -She thought the yellow ointment might have been a barrier cream, but she was not sure. -The nurse would give her the ointment in a medicine cup. *She said that resident 20 had a bath the other day, and the nurse asked her to apply the yellow ointment and the bandage on his bottom. Interview on 2/27/25 at 7:47 a.m. with DON A revealed: *Resident 20 had Optifoam dressings on the back of his thighs directly underneath his buttocks, and on his coccyx region. *The wounds on the back of his thighs were from an abrasion due to his briefs. He would slide back and forth in his recliner, which she thought caused friction abrasions. *He was independent with ambulation and toileting. *She confirmed it was not normal practice for a licensed nurse to delegate a treatment of applying a resident's ointment and dressing to a CNA. Review of the provider's March 2012 CNA job description revealed: *Job Summary: Under general supervision performs a combination of following duties in caring for residents in the Center, consistent with the plan of care and established long-term care standards and Center policies and processes. The CNA is expected to perform duties in compliance with state and federal regulations. *Reporting Relationships: 1. Reports to the Licensed Nurse directing and overseeing resident care on assigned unit. Review of the Administrative Rules of South Dakota (ARSD), Chapter 20:48:04.01 for Delegation of Nursing Tasks revealed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*20:48:04.01:01. General criteria for delegation. A licensed registered nurse is responsible for the nature and quality of nursing care that a client receives under the nurse's direction. A licensed nurse may delegate selected nursing tasks to a nursing assistant. A nursing assistant may not substitute for the licensed nurse in the performance of nursing functions. A nursing assistant may not redelegate a delegated task. *A licensed nurse shall assess a situation and determine whether delegating nursing tasks to a nursing assistant is appropriate. The delegation of nursing tasks to a nursing assistant must comply with the following criteria: -(1) The nursing task is one that a reasonable and prudent licensed nurse would find within the scope of sound nursing judgment to delegate; -(2) The nursing task is one that, in the opinion of the delegating nurse, can be properly and safely performed by a nursing assistant without jeopardizing the client's welfare; -(3) The nursing task does not require a nursing assistant to exercise nursing judgment; -(4) The licensed nurse evaluates the client's nursing care needs before delegating the nursing task; -(5) The licensed nurse verifies that the nursing assistant is competent to perform the nursing task; and -(6) The licensed nurse supervises the performance of the delegated nursing task in accordance with the requirements of ARSD Chapter 20:48:04.01:02. *20:48:04.01:02. Supervision. The licensed nurse shall supervise all nursing tasks delegated to a nursing assistant in accordance with the following conditions: -(1) The licensed nurse determines the degree of supervision required after considering: --(a) The stability of the client's condition; --(b) The competency of the nursing assistant to whom the nursing task is delegated; --(c) The nature of the nursing task being delegated; and --(d) The proximity and availability of the licensed nurse to the nursing assistant when the nursing task is performed; -(2) The delegating nurse or another licensed nurse is readily available either in person or by electronic communication . 50915 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. Observations and interviews made throughout the survey revealed residents 12 and 49 had not been repositioned or transferred on a routine basis, which potentially contributed to the development of pressure ulcers on resident 12's coccyx first noted on 2/23/25, and on resident 49's coccyx first noted on 2/27/25. Interviews with RN E and RN R indicated they had not assessed resident 12's wound and had not obtained orders from a physician for treatment. Interviews with RN E and RN R indicated resident 12's hospice service was managing the wound, so they did not assess or treat the wound. Interviews with DON A throughout the survey revealed that she was not aware of resident 12's pressure ulcer, and she expected staff to conduct their own assessments and obtain treatment orders whether a resident was on hospice or not. Refer to F686, findings 14 through 27 regarding resident 12. 3. Observations and interviews throughout the survey revealed that resident 49 was experiencing consistent pain with repositioning. There were several instances where he was heard moaning and shouting out in pain. He was seen grimacing in pain. Record review revealed that he had orders for as needed pain management, but that had not been administered due to pain assessment documentation showing as a 0 out of 10 on three separate occasions on 2/25/25. Interviews with hospice staff revealed that they had concerns about previous residents and their pain, which was to be managed by the provider. By not recognizing that the resident was experiencing increased pain and not administering the prescribed pain medication, resident 49 experienced pain with personal cares and repositioning. Refer to F697.

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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** 50916 Based on observation, interview, record review, policy review, and job description review, the provider failed to develop and implement pressure relieving measures to ensure facility acquired pressure ulcers had not developed for three of five sampled residents (10, 12, and 49) who were identified at high risk for skin breakdown and dependent upon the staff assistance with their activities of daily living (ADL). Findings include: 1. Observation on 2/25/25 at 10:08 a.m. of resident 10 revealed: *He was in his room and lying on the bed with a nursing home gown on. *He was laying mostly on his back with a pillow placed underneath of his right arm. -His body was positioned and was facing towards the wall with the upper portion of his body towards the left of the bed. -From his waist down his body was laying on the right side of the bed. -His buttocks and thighs laid directly on the mattress. *There was a heel lift device underneath the lower part of his legs to help decrease pressure from the mattress on his heels. -He had been positioned low in the bed and his left foot was flat up against the footboard. *His left ankle was laying directly on the edge of the mattress and his right heel was laying directly on the mattress. -There was no pressure relief for his left ankle from the edge of the mattress or his foot from the footboard. *He had been awake and watching television. 2. Random observations on 2/25/25 from 11:10 a.m. through 2:20 p.m. and interview with resident 10 revealed: *He had been lying in the same position as observed above. *He was either sleeping or watching television during those observations. *He had a towel placed underneath his chin that had a brown stain on it from some type of liquid. *He was not observed getting out of bed for breakfast or lunch. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*When asked if he was getting out of bed today, he asked what day it was and then stated, Yes. 3. Interview on 2/26/25 at 7:27 a.m. with registered nurse (RN) B revealed: *Resident 10 had a stage two pressure ulcer (wound with partial thickness skin tissue loss from prolonged pressure) on each heel. *She had already completed his pressure ulcer wound care that day. 4. Observation on 2/26/25 at 8:00 a.m. of resident 10 revealed: *He had been lying in bed with his body propped onto his left side by a pillow. *His feet, ankles, and heels were in the same position as observed the day before (2/25/25). 5. Interview on 2/26/25 at 8:05 a.m. with certified nursing assistants (CNAs) V and W regarding resident 10 revealed: *He did not like to get out of bed and often refused. *He could reposition himself but they would have to verbally cue him to turn over. *The surveyor had requested to watch them provide personal cares for him. *CNA V stated: Not sure when today but will at some point. 6. Random observations on 2/26/25 from 8:45 a.m. through 12:10 p.m. of resident 10 revealed he had been in the same position as observed above for the entire morning. At 12:10 p.m. CNA W came and got the surveyor to observe them providing his personal care. 7. Observation on 2/26/25 at 2:49 p.m. of resident 10 revealed he was in his wheelchair at bingo. 8. Observation and interview on 2/27/25 at 7:18 a.m. with RN B while she provided wound care treatment to resident 10 revealed: *He had given the surveyor permission to observe his wound care. *He had a stage two pressure ulcer on his right and left heels. *He had an abrasion on his coccyx (tail bone). *RN B stated the wounds were facility acquired. *Staff were to complete wound assessments once a week. *Skin assessments were to be completed weekly on the residents' bath days, and they label a yes or no if there was a new skin condition or not. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*If there was a new skin condition, then staff would complete a weekly skin evaluation form. 9. Interview on 2/27/25 at 12:27 p.m. with director of nursing (DON) A revealed: *She thought all facility acquired pressure ulcers were preventable including resident 10's. *She did not think the staff were providing the residents' pressure ulcer prevention measures or completing skin assessments on residents who had risks of acquiring pressure ulcers. *She wanted to start plan of care (POC) charting task that would include including repositioning residents every two hours and toileting. *She planned to start staff competencies including what to look for during skin assessments and how to document them. 10. Review of resident 10's electronic medical record (EMR) revealed: *An admitted [DATE]. *He had a Brief Interview for Mental Status (BIMS) assessment score of 15 which indicated he was cognitively intact. *His diagnoses included venous insufficiency, hypertension, chronic kidney disease, and diabetes. *He was dependent on staff for bathing, bed mobility of moving right and left, transferring out of bed, toileting, and implementing any preventative interventions to ensure skin breakdown would not have occurred. *A stage two pressure ulcer was acquired on his right heel on 8/26/2024. *A stage two pressure ulcer was acquired on his left heel on 1/3/2025. *A superficial abrasion to his coccyx was acquired on 2/25/25. 11. Review of resident 10's care plan last updated on 5/30/2024 related to his skin integrity included: *Focus: I have the potential for pressure ulcer development r/t [related to] Hx [history] of ulcers, immobility. *Goal: I will have intact skin, free of redness, blisters or discoloration by/through review date. *Interventions: -Elevate/float heels when in bed to offload pressure as I allow. -Follow facility policies/protocols for the prevention/treatment of skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Frequent repositioning while resting. -Inspect skin while providing cares, notify nurse of any new skin conditions. -Instruct/assist/encourage me to shift weight in W/C [wheelchair] routinely. -Pressure reducing air mattress to bed. -Pressure reducing cushion to wheelchair. *There was no indication on his care plan that he had any pressure ulcers or abrasions on his skin. 12. Review of resident 10's Braden Scale for Predicting Pressure Sore Risk assessments revealed: *On 2/23/24 and 5/17/24 his score was a fourteen which indicated he had moderate risk for the development of a pressure ulcer. *On 8/13/24 and 9/16/24 his score was a fifteen which indicated he had mild risk for the development of a pressure ulcer. *On 12/13/24 his score was a sixteen which indicated he had a mild risk for the development of a pressure ulcer. 13. Review of a 2/24/25 weekly skin evaluation for resident 10 signed by RN B revealed: *The left heel had a stage two pressure ulcer acquired on 1/3/25. It: -Had minimal drainage and measured 1 centimeter (cm) in length, 1 cm in width, and 0 cm in depth. -Required pressure-reducing interventions including a mattress and boots. -Had a dressing order to cleanse, pat dry, apply silicone cream, cover with Optifoam (a type of wound dressing), and change daily. *The right heel had a stage two pressure ulcer acquired on 8/26/24. It: -Had no drainage and measured 1 cm in length, 2 cm in width, and 0 cm in depth. -Worsened from a stage one on 2/17/25 to a stage two on 2/24/25. -Had the same dressing order as the left heel. 46453 14. Random observations on 2/25/25 from 9:45 a.m. through 2:20 p.m. of resident 12 revealed: *She had been in her room sitting in a recliner. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	*Her feet were elevated by the footrest, and she appeared to have been sleeping. *Staff were not observed assisting her to offload or reposition/transfer to another location such as her bed. 15. Observation on 2/25/25 at 3:18 p.m. of resident 12 in her room revealed: *She had been moved to her wheelchair. *She was sitting on an inflatable cushion. 16. Random observations on 2/26/25 from 7:45 a.m. through 11:20 a.m. of resident 12 revealed: *There was a heel lift device (a device that helped decrease the pressure from the mattress on a person's heels) that was not in use. It was sitting on the other bed in her room. *She had been lying in her bed sleeping. *She had an air mattress overlay on her bed to help with relieving pressure to any areas that would have been at risk for skin breakdown. *She had been laying on her back, both of her heels were positioned directly on the air mattress, and the bottoms of her feet were positioned against the footboard of the bed. *She remained in that position for over three hours. *At 8:00 a.m. the surveyor asked CNA D to observe them assisting the resident. He stated that he would come and get that surveyor when that happened. 17. Review of resident 12's EMR revealed: *A nursing progress note from 2/23/25 at 11:30 a.m. that read, Called [hospice provider] to update on Res [resident] refusing pain medication and new skin issues. Hospice nurse will come to assess resident today. *A scanned Coordination Notes Report hospice note that was signed as noted by DON A on 2/25/25. -It included six pages of notes and assessment details. DON A signed the first page. -On 2/23/25, RN E called the hospice triage phone number to discuss concerns with resident 12 refusing pills and [RN E] states that she believes [resident 12] may be developing a Kennedy ulcer [an ulcer that can develop rapidly as a person is in the dying process] on her coccyx, as she has discoloration that is purple in color and described as a stage 1. -[Resident 12] also has an injury to the back of her left thigh caused by catheter tubing pressing against her skin. -No current wound care orders for either area are present at [the] facility at this time. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-[RN E] does not think skin issues have been assessed by hospice yet. -Later in the day on 2/23/25, a hospice RN was present at the facility and noted that RN E was present to assist with assessments. -Wound measures 2.5cm [centimeters] [by] 7.5cm dark purple area with a 1.5cm [by] 1.5cm open area in the center. Wound picture taken and care plan updated. Orders placed along with calendar updated. *A weekly skin audit had been completed on 2/20/25 after her bath with no new skin impairment identified. *There were no physician's orders or wound assessments found regarding the skin impairments on her coccyx and thigh. 18. On 2/26/25, a list of all residents with current skin and wound concerns was requested and interview on 2/26/25 at 8:27 a.m. with DON A regarding that list revealed: *Resident 12 was not on that list. *She was not aware that resident 12 had any skin issues relating to her coccyx or thigh. *She was aware that the hospice provider wanted to look at her skin, but she was not aware of any current skin issues. *Additional documentation relating to wound assessments and treatment orders was requested relating to resident 12's wounds. Continued interview on 2/26/25 at 8:35 a.m. and 9:27 a.m. with DON A revealed: *She could not find any orders from hospice regarding wound care. -She had to call the hospice provider to obtain their wound assessments and treatment orders. *She did not know if resident 12's primary care physician was notified of the wounds. *She confirmed she missed the wound assessment note from hospice on 2/23/25. *She confirmed she had signed her initials on that hospice note on 2/25/25. *They had recently changed their process on how they were to complete residents' weekly skin assessments. -Previously, the nurse would complete a weekly skin audit evaluation on each resident. -Now, they have a yes or no question that was triggered weekly. The nurse would check yes if there was a skin issue and that would trigger a full skin assessment. If no was checked, that meant no new skin impairments. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*They implemented the following measures to prevent pressure ulcers for resident 12: -An air mattress. -The cushion for her wheelchair. -[NAME] brand skin barrier cream. 19. Observation and interview on 2/26/25 at 10:20 a.m. with RN X regarding resident 12 revealed: *She was massaging resident 12's hands and washing her face. *She was the hospice care case manager and had come in that day to see the resident. *She was not there to complete personal care for the resident but to offer comfort and support in other measures. *She would have expected the residents on hospice care to have been repositioned at a minimum of every two hours. *The resident had recently acquired a Kennedy ulcer to her coccyx area. -That ulcer had the potential to worsen when proper repositioning had not occurred. *They would have completed a wound assessment for their own purposes and records. -That skin assessment would not have been provided for the facility's records. -The facility was responsible for completing their own skin assessments. -The residents were still the primary responsibility of the facility. -She explained that hospice services were an additional support for the resident. 20. On 2/26/25 at 11:20 a.m., CNA U came and got the surveyor to observe them assisting the resident. That had been the first time in the morning that the staff had assisted her with repositioning and personal care. 21. Interview on 2/26/25 at 12:58 p.m. with RN E about resident 12's wound revealed: *She noticed the bruise on resident 12's coccyx on Sunday 2/23/25. The area was purple. *She did not assess it at that time because I didn't want to be pressing on it. I didn't know if it was a deep tissue injury. *She called the hospice provider because Hospice takes care of the wound care orders and the assessments. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The hospice provider indicated that they would send someone that day to assess the wound. *She did not notify the resident's primary care physician, saying, I didn't even think to do that. -She also did not notify the DON because she did not want to disturb her on a Sunday. *She passed the information along to RN R who was the oncoming nurse for the next shift. *For pressure ulcer preventative measures, she expected staff to reposition resident 12 on a regular basis, such as moving from the bed to a chair, shifting to different positions in the chair, and moving her to the wheelchair. *Resident 12 had an air mattress on her bed and a cushion in her chair for pressure redistribution. 22. Observation on 2/26/25 at 1:08 p.m. of resident 12 revealed that she was dressed for the day and had been moved to her recliner. 23. Observation on 2/26/25 at 4:07 p.m. of resident 12 revealed that she was still sitting in her recliner. The recliner was in a slight reclined position. 24. Interview on 2/26/25 at 4:53 p.m. with RN R revealed: *She confirmed she was present at the facility on 2/23/25 when the hospice nurse came to assess resident 12's wounds. *She did not perform a wound assessment because hospice did the assessment. -The hospice nurse measured the wound. -She asked me to apply Optifoam and that's it. -At the time of the assessment, resident 12's coccyx was red and there was a little bit of scraping and bleeding. *She did not notify the resident's primary care physician because they have their own hospice physician and hospice staff notify the physician. *She did not notify the DON. *She indicated that if the hospice nurse had a new order, she would have entered it into the EMR system, and the DON would have been notified that way. -There were no new orders that she entered from hospice regarding that wound. *Wound treatments were usually completed during the day shift. 25. Interview on 2/27/25 at 8:05 a.m. with DON A revealed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*She expected staff to complete assessments on wounds when they were noticed right away, complete the skin evaluation, and notify the family and physician. *They used telehealth services to obtain treatment orders. *That process should not change due to a resident receiving hospice services. *She explained that hospice was an additional service, and staff should not be passing along the responsibility of caring or a resident onto the hospice service. 26. Review of resident 12's current care plan revealed: *She was completely dependent on staff and required substantial to maximum assistance for ambulation, transferring, and repositioning. *One intervention read, Skin at risk: Barrier cream, Lotion to dry skin, Pressure reducing mattress, Specialty mattress: Air Mattress, Turn/reposition routinely, Wheelchair cushion. Initiated on 10/4/23. Revised on 1/31/24. *There were several interventions that mentioned she experienced frequent loose stools and was incontinent of her bowels. Her care plan indicated for Staff to cleanse and keep skin dry. Apply barrier cream BID [twice per day] and with each incontinent episode. *She preferred to lay on her back and would only reposition to her side for short periods of time. *Pressure-reducing measures included the specialty air mattress and a pressure reducing cushion in her wheelchair. *She had a history of a venous ulcer to the bottom of her right foot. *Another intervention that read, Utilize pillows/foam wedges for placement between bony prominences. Initiated on 3/16/25. Revised on 2/13/24. 27. Review of resident 12's EMR revealed: *Her diagnoses included endometrial cancer, multiple sclerosis, type 2 diabetes, peripheral vascular disease, and congestive heart failure, among others. *A significant change Minimum Data Set assessment was completed on 1/6/25 that included: -Her BIMS assessment score was 10, which indicated she was moderately cognitively impaired. -She was dependent on staff to transfer from surface to surface. -She required substantial to maximum assistance for repositioning. -She had a catheter due to a neurogenic bladder, and she was always incontinent of bowel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-She was at risk for developing pressure ulcers. -She did not have any pressure ulcers at the time of the assessment. 50915 28. Observations on 2/25/25 from 9:45 a.m. through 3:00 p.m. of resident 49 revealed: *At 9:45 a.m., the resident was laying on his back with a pillow under his back on the right side, but mostly flat. *At 1:10 p.m., the resident was laying in the same position, mostly flat, with a pillow under his back on his left side. *At 2:15 p.m., the hospice nurse was at his bedside, the pillow was moved to right side, and the resident laying mostly flat. *At 3:00 p.m., his position was unchanged. 29. Interview on 2/26/25 at 7:50 a.m. with RN E revealed resident 49 was to be repositioned every two hours to help prevent pressure ulcers. 30. Observation and interview on 2/26/25 at 8:10 a.m. with certified medication aide (CMA) D revealed: *He was repositioning resident 49 every two hours. *He reported the resident's condition had significantly declined over the past few days. *During observation of repositioning, resident 49 was unable to follow commands and moaned in pain when moved. 31. Observations on 2/26/25 of resident 49 revealed: *At 9:00 a.m. he had been in bed and was laying on his back. -The extra pillow had been placed above his head. -Both of his feet and heels had been laying directly on the mattress with no pressure relieving device in place. -He had been positioned down low on the mattress to where his feet rested directly up against the footboard. 32. Interview on 2/26/25 at 12:30 p.m. with CNA U revealed: *Residents should have been repositioned every two hours. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*He agreed: -Residents 12 and 49 were dependent upon the staff to reposition them. -Those residents were vulnerable and were at risk for skin breakdown and should have been repositioned every two hours. *His partner had left early that day, and he was left by himself to reposition them. -He confirmed those residents had gone longer than two hours without being repositioned. *He agreed: -Repositioning residents with their feet directly against the footboard created the potential for skin breakdown to have occurred. -The residents' heels should not have been left directly on the mattress. A heal lift should have been used to relieve the pressure. 33. Observation on 2/26/25 at 4:30 p.m. of CNA K revealed: *She was changing resident 49's brief because he had been incontinent. *There was a bandage on resident's buttock. *CNA was not sure what the bandage was covering but would let the charge nurse know it was starting to peel away from his skin. 34. Interview on 2/26/25 at 5:20 p.m. with hospice nurse RN G revealed: *She reported doing resident 49's skin assessments. *She reported there was some redness to the resident's coccyx, but did not believe there were any pressure ulcers. 35. Observation and interview on 2/27/25 at 10:47 a.m. with RN B revealed: *She was performing skin cares on resident 49's coccyx and buttocks. *After removing cream from resident's coccyx, two open area were revealed, each measuring approximately one centimeter (cm) around. *She reported these to be stage two pressure ulcers. *She reported this was the first time she had seen these ulcers. *She reported when performing resident cares on 2/24/25, the ulcers were not present. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*She did not feel the ulcers could have been prevented because resident was repositioned appropriately. 36. Interview on 2/27/25 at 12:33 p.m. with DON A revealed: *She found out about resident 49's pressure ulcers earlier in the morning. *Regarding resident 49's pressure ulcers, she felt they were absolutely preventable. *Regarding facility acquired pressure ulcers, she felt they are all preventable. *She did not think CNAs received appropriate training. *She felt sometimes staff did not listen to her guidance in regard to the education she provided them. *She wanted to implement POC [point of care] documenting. (The care is documented at the time it occurs, not when it is scheduled). This would increase accountability of completing resident tasks. *It was her expectation for staff to follow her instructions. *She planned to implement a competencies program with a skills checklist. -She was hopeful with the hiring of a new assistant DON education of staff and competencies could soon become a priority. 37. Review of resident 49's EMR revealed: *He was admitted to hospice care on 2/18/25. *His BIMS assessment score was three, which indicated he was severely cognitively impaired. *He had medical diagnoses including Alzheimer's/dementia with behaviors, fall with major injury, right humerus fracture, congestive heart failure, and depression. *He was dependent upon the staff to: -Assist him with all of his mobility needs (repositioning in bed) and ADL. -Implement any preventative interventions to ensure skin breakdown would not have occurred. -Anticipate his needs as he was unable to make them known. *His Braden Scale score on 2/20/25 was sixteen. -That score had indicated he was at mild risk for skin breakdown. *On 2/27/25 his Braden Scale score was reassessed and was an eight. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Within seven days his skin breakdown risk had increased to a very high risk. *The first documentation of his pressure ulcers was in nursing progress note on 2/26/25 at 11:59 p.m. by RN R, after his skin bandage was witnessed earlier in the day. -Resident in bed PM cares. Reposition to sides. No intake. Took his comfort meds. Hospice nurse here after supper. Both writer & hospice nurse [name], we did measure open sores. Coccyx one cm [centimeter] x 3/4 cm. Right cheek [buttock] 1 cm x 3/4 cm. 38. Review of resident 49's care plan revealed: *A focus of I have the potential for impairment to skin integrity r/t [related to] edema, fragile skin. *Goals of The resident will maintain or develop clean and intact skin by the review date. The resident will be free from injury through the review date. *Interventions/tasks of Avoid scratching and keep hands, and body parts from excessive moisture. Follow facility protocols for treatment of injury. Keep skin clean and dry. Use lotion on dry skin. The resident needs pressure reducing cushion to protect the skin while up in chair. The resident needs pressure reducing mattress to protect the skin while IN BED. Use draw sheet or lifting device to move resident. 39. Review of the provider's January 2025 Skin Integrity policy revealed: *In the event that a resident is admitted with or develops a skin ulcer/pressure ulcer/wound, care is provided to treat, heal, and prevent, if possible, further development of skin ulcers/pressure ulcers/wounds. *1. The nurse completes the Braden Scale/Skin Integrity Evaluation at admission, weekly for three weeks, and then annually. The Braden Scale is s guide to determine risk stratification for skin impairment. -a. Residents are at a level of risk per the Braden scale and the completion merely guides the practitioner to determine if future intervention is required. -2. The nurse establishes a plan of care based on risk factors in an effort to limit their potential effects. -3. The resident's skin is inspected daily with completion of ADL's [activities of daily living] (unless resident is independent in ADL completion). Changes in the resident's skin are reported to the Licensed Nurse (LN). -Ongoing evaluation continues weekly with the LN completing a full body skin audit. Completion of the skin audit is documented on the Treatment Administration Record (TAR) with their initials, and either a 'No' or 'Yes.' *If skin impairment is noted after admission, the LN: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-a. Initiates alert charting. -b. Completes (and documents) notifications to the physician and Resident or Resident Representative. -c. Implements new interventions as needed. Documents on the resident's care plan and ISP. -d. Notifies Food and Nutrition Services Manager (FANS) and/or Registered Dietician of new pressure injury or worsening wound condition for nutritional needs evaluation. -e. Notifies Director of Nursing Services (DNS) of skin Impairments that indicate a potential significant change in condition (State II or greater Pressure Ulcer, surgical wound dehiscence, hematoma, or bruise on an area of the body not usually vulnerable to trauma (e.g. head, breasts, inner thighs, groin). -f. The DNS and/or designee complete a comprehensive review of the resident's medical record to evaluate if the pressure injury was avoidable or unavoidable. This evaluation is documented in the Nurse's Notes. *If a wound condition fails to improve after 2 weeks of treatment or the condition of the wound deteriorates, the Physician and Resident's Representative are notified. 40. Review of the provider's March 2012 CNA job description revealed: *Essential Functions: .5. Turns and repositions bedfast residents, alone or with assistance, and utilizing proper body mechanics, to prevent pressure ulcers.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 50915 Based on observation, interview record review and policy review provider failed to recognize and adequately manage pain for one of two hospice sampled resident (49). Findings include: 1. Observation on 2/25/25 at 2:11 p.m. revealed: *Resident 49 was being repositioned by certified nursing assistant (CNA) F and hospice registered nurse (RN) G. *Resident 49 could be heard in the hall moaning. *Resident grimaced and moaned in pain with any repositioning. 2. Observation and interview on 2/26/25 at 8:31 a.m. with CNA D revealed: *CNA was repositioning and checking resident 49 for incontinence every two hours. *Resident 49 grimaced and moaned in pain with even small movement. *Resident 49 would shout help, help with repositioning. *CNA made effort to be very gentle with the resident, but the resident was still in pain. *He reported resident 49 has had increased pain with repositioning for the past several days. *CNA reported his increased pain to RN E. 3. Interview on 2/26/25 at 8:40 a.m. with RN E revealed: *She tried to assess resident 49's pain as often as possible. *She also relied on the CNAs to let her know if he was having increased pain. *She was aware he was having increased pain with repositioning. *She did not feel his pain was adequately controlled with pills; she would prefer liquid morphine for pain control for a hospice resident. 4. Interview on 2/26/25 at 1:30 p.m. with director of nursing (DON) A and RN C revealed: *It was DON A's expectation resident 49 would be repositioned every two hours. *RNC C stated pain should be assessed every shift. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	*There were changes to resident 49's medication that day and DON A would like to see if the new medication was effective in relieving the resident's pain. 5. Phone interview on 2/26/25 at 2:15 p.m. with hospice RN G revealed: *She had no concerns with the quality of care resident 49 was receiving from the provider's staff. *She recognized the resident's increased pain during her previous visit and requested a change of pain medication to scheduled morphine. *She reported observing past hospice residents not having their pain controlled. She reported she thought resident pain was perceived as behavior issues. 6. Observation and interview on 2/26/25 at 4:30 p.m. with CNA K revealed: *CNA K was repositioning and checking the resident's brief for incontinence. *She reported the resident appeared to be more comfortable than usual. *She reported the resident seemed to have a lot of pain with movement and repositioning. 7. Review of resident 49's electronic medical record (EMR) revealed: *He was admitted to hospice care on 2/18/25. *His brief interview for mental status (BIMS) score was was 3, which indicated he was severely cognitively impaired. *He had medical diagnoses including right humerus fracture, congestive heart failure, and depression. *Nursing progress note on 2/25/25 at 1:11 a.m. documented by licensed practical nurse (LPN) S noted Repositioned q [every] 2 hrs [hours]. He is lethargic, but yells every time he is touched. Refuses to eat, drink, and take medication. 8. Review of resident 49's 12/30/24 care plan revealed: -A Focus of I am on pain medication therapy r/t [related to] injury to R [right] Humerus fx [fracture]. -Goals of The resident will be free of any discomfort or adverse side effects from pain medication through the review date. -Interventions/tasks of Administer ANALGESIC medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT [every shift]. -A Focus of I have an alteration in musculoskeletal status r/t fracture of the R Humerus. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Goals of The resident will remain free from pain or at a level of discomfort acceptable to the resident through the review date. -Interventions/tasks of Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness. -A Focus of I have identified PAIN that interferes with sleep, rehabilitation activities, day to day activities Depression, Fracture of R Humerus. -Goals of The resident will not have an interruption in normal day to day activities due to pain through the review date. The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. The resident will display a decrease in behaviors of inadequate pain control such as irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, groaning, crying through the review date. -Interventions/tasks of Administer analgesia as per orders. Give 1/2 hour before treatments or care. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. 9. Review of resident 49's treatment administration record (TAR) revealed: *His pain was to be monitored each shift, at 7:00 a.m, 3:00 p.m., and 11:00 p.m. *On 2/25/25 at 7 a.m., RN CC documented the resident's pain was 0 out of 10 during repositioning, indicating the resident had no pain. *On 2/25/25 at 3 p.m., RN R documented resident's pain 0 out of 10. *On 2/25/25 at 11 p.m., LPN DD documented resident's pain 0 out 10 *Resident 49 had a physician's order to receive 2.5 milligrams (mg) of Oxycodone (narcotic pain medication) every hour as needed for pain. *On 2/25/25, resident 49 did not receive Oxycodone for pain. 10. Review of the provider's 1/2025 pain management policy revealed: *Policy Statement: It is the policy of the center that residents receive care to attain and maintain the highest quality of care and life. *Residents are evaluated for pain upon admission, routinely, and prn [as needed] with the RAI [resident assessment instrument] process. *Procedure: 2. The resident is evaluated every shift for signs and symptoms of pain, receiving pain management according to the Preliminary Plan of Care and/or physician order. This data is collected on the medication administration record (MAR), in the interdisciplinary progress notes and through the Daily Clinical meeting process. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	*An appropriate pain scale is selected for use based upon resident ability and needs. Examples may include but are not limited to: Numeric 1-10, Verbal Descriptor Scale, Wong-Baker Faces, and the Pain AD (Pain Assessment in Advanced Dementia). *11. If the resident is a hospice client or receiving palliative/comfort care the nurse and the hospice manager collaborate to develop and evaluate the pain management plan of care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46453 Based on observation, interview, record review, and policy review, the provider failed to maintain standard food safety practices including: *Unsanitary kitchen equipment and food storage and preparation areas including the dishwasher, the stovetop range, the convection oven, the walk-in cooler and freezer, the emergency food supply area, and the kitchenettes. *Improper food storage throughout the facility including storing foods past its quality date, storing foods that were visibly rotting, unsealed foods open to air in the cooler, storing raw meats above milk cartons, storing foods on the floor in the cooler, storing measuring scoops inside food thickener, and not labeling or dating bulk food ingredient items. *Improper hand hygiene and glove use during one of one meal service observations by two of two staff members (dietary manager L and an unidentified staff person). *Incomplete temperature monitoring for two of at least three communal resident food and beverage refrigerators. Findings include: 1. Observation during the initial kitchen tour on [DATE] from 8:28 a.m. through 9:09 a.m. of the dish room revealed: *There was a fan blowing into the dish room. The back of the fan was covered with a thick layer of dust. *A large section of the tile flooring, about three feet by nine feet, was missing, and the subfloor beneath it was exposed. *There was a large puddle of water under the dishwasher. *The metal paneling under the dishwasher was coming loose from the floor. Water splashed out from underneath the metal paneling when it was stepped on. *There was a limescale buildup throughout the dishwasher: -On both the top and bottom wash arms. -On top of the dishwasher. -Along the edges of the dishwasher doors. *There was a thick layer of food scum buildup along the top inside edge of the dishwasher. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*The ventilation hood above the dishwasher had a buildup of rust and wet dust, suggesting poor ventilation from that hood. *The paint on the ceiling was peeling off. *Interview at that time with dietary manager L revealed: -One of the cooks was responsible for deliming the dishwasher every Wednesday. There was no documentation to show when that was last completed. -He was aware that the ventilation hood might not have been functioning properly. 2. Observation during the initial kitchen tour on [DATE] from 8:28 a.m. through 9:09 a.m. of the main kitchen area revealed: *The drip tray under the stovetop range was filled with food crumbs, burnt-on stains, and burned rotini noodles. *The backsplash of the stovetop range and flattop grill was stained black with burnt-on grease stains. *The tunnel that went from the flattop grill to the grease trap drawer was caked with black grease. *The trash can to the left of the stovetop was uncovered. There was a cover available and hanging off the trash can. *There were two ovens stacked on top of each other. The inside of the bottom oven was covered in burnt-on food and grease. *There were three bins of bulk food ingredients. One bin contained rice, another bin contained what looked like sugar, and the third bin contained what looked like flour. None of the bins were labeled or dated when they had been filled. *There was another uncovered trash can to the left of those bulk food ingredient bins. The cover was lying on the floor under the trash can. *There were several large containers of dried spices. Some of the containers had been there for several years, including a bottle of dried oregano with a delivery date of [DATE]. 3. Observation during the initial kitchen tour on [DATE] from 8:28 a.m. through 9:09 a.m. in the walk-in cooler and freezer revealed: *There was an abundance of an unidentified black and white fuzzy growth on the walls, door frame, floor, and shelving units that appeared to have been mold. *The floor in the cooler was vinyl flooring that was damaged and curling up. *There was a buildup of dirt, food scraps, and packaging on the floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*There was a crate of four gallons of milk sitting directly on the floor. *A box of raw bacon was stored directly above several gallons of chocolate milk. *Several food items were past the manufacturer's best by date: -Three jars of Grey Poupon mustard, one opened, with the best by date of [DATE]. -One case of at least 10 jars of parmesan cheese with a best if used by date of [DATE]. That case was delivered on [DATE]. *Several food items had started to rot: -Two bags of celery were visibly turning brown and mushy. -One bag of lettuce was starting to [NAME] and turn brown. There was brown liquid in the bag. *The wooden floor inside of the freezer had turned black. There was an abundance of dirt, food, dust, and food wrappers. *Refer to F908, finding 1, for details on how the cooler and freezer were malfunctioning. 4. Observation during the initial kitchen tour on [DATE] from 8:28 a.m. through 9:09 a.m. revealed in the storage room where the emergency food supply was stored: *There was a layer of dust, dirt, and cobwebs on the emergency food supply. *Most of the food in the emergency supply was delivered on [DATE] and was past the manufacturer's best by date. 5. Observation on [DATE] from 12:54 p.m. to 1:38 p.m. during the lunchtime meal service revealed: *An unidentified staff person wore the same pair of gloves throughout the meal service and did not wash his hands. With those gloved hands he: -Pushed a cart of drinks and served them to residents. -Pushed a resident in their wheelchair to her designated table. -Grabbed coffee mugs and plastic cups, poured drinks into them, and served them to residents. -Grabbed a tray of drinks from the fridge. -Grabbed a stack of plastic cups and poured multiple juices and set them on the tray of drinks. -Put the tray of drinks back in the fridge and covered them with another tray. -Grabbed dessert cups by the rim and scooped a blueberry dessert into them. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Grabbed an individual butter condiment from a container full of butter condiments and placed it on a plate of mashed potatoes and roast beef and served that plated food to a resident. -Grabbed a package of crackers from a container full of packaged crackers and placed it on a plate along with a soup spoon he retrieved from a container of soup spoons and served those items to a resident. -Opened a cupboard in the kitchenette and pulled out a cup and lid. -Opened a single-serve ice cream for a resident. -Placed plastic wrap on top of juices and desserts for resident room meal trays. *Dietary manager L prepared a resident's plate while wearing gloves, removed the gloves, and served the plate of food to the resident without washing his hands. *Dietary manager L put on one glove, served a plate of food to a resident, removed the glove and did not wash his hands. 6. Observation on [DATE] at 12:57 p.m. of the refrigerator labeled Drink Fridge in the main dining room revealed: *The temperature monitoring sheet had several slots with no temperatures recorded. *Those unrecorded temperatures included the AM and PM slot on [DATE] and the PM slot from [DATE] through [DATE]. 7. Observation on [DATE] at 1:25 p.m. in the activity room kitchenette revealed: *The temperature monitoring sheet on the refrigerator labeled Snack Fridge had several unrecorded temperatures including: -The PM slot from [DATE] through [DATE]. -The AM slot on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. *In the snack fridge, there were several containers of what looked like chocolate pudding that had been scooped into individual plastic serving cups. -There was no label that identified what it was. -There was no date that indicated when it was dished. *In the closet, there were at least three cases of sugar-free chocolate and vanilla pudding with a best if used by date of [DATE]. *The hot-holding steam table a buildup of rust, food crumbs, and dead flies in the basins. It was not used during the survey. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*There was a damp rag balled up in the sink that had a foul odor coming from it. There were no detergent or sanitizer buckets to store the rag in. 8. Interview on [DATE] at 9:23 a.m. with FANS cook Q revealed: *There were cleaning checklists designated for each position and shift. -She indicated that the checklists were not used that often. -She did not know where the completed checklists were supposed to have been turned in. *She thought that one of the other cooks delimed the dishwasher every Saturday. *The person who put the groceries away was supposed to go through the cooler and freezer and discard the old and expired foods. 9. Continued observations on [DATE] at 9:38 a.m. in the walk-in cooler revealed: *A box of ground beef and a crate of four gallons of milk sitting directly on the floor. *A sheet pan of breadsticks that were not covered, labeled, or dated. 10. Interview on [DATE] at 9:56 a.m. with executive director I revealed: *He was new to his position as of the previous week. *He was not aware of the above observed dietary department concerns. *He agreed that the issues needed to be addressed. 11. Observation on [DATE] at 1:51 in the main dining room kitchenette revealed: *The missing temperatures from the drink fridge temperature monitoring sheet were now all filled out. *A jar of peanut butter on the shelves above the steam table had a manufacturer's best by date of [DATE]. *An unnamed refrigerator contained the following expired foods: -Eight chocolate pudding cups with best by dates of [DATE]. -Two cartons of decaffeinated coffee concentrate for the coffee dispenser with a manufacturer's code of Consume Before [DATE]. *There were two bottles of unopened mustard in the cupboards with a best by date of [DATE]. *There was a small fan in the cupboard above the serving line that was covered in dust. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*There was a container of Prairie Farms Sour Cream on the counter that had Thickener ,d+[DATE] written on it. -There was white powder on the inside which appeared to be powdered food thickener. -The scoop was sitting in the thickener. -There were no directions included with the packaging of how to use the food thickener, or how many scoops were required for the different thickness levels. *There was another clear plastic container that was labeled ,d+[DATE] Thickener. -The scoop was sitting in the thickener. -There were no directions on that container. *The space beneath the steam table was very rusty and had food crumbs and scrambled eggs scattered throughout. An electric flattop griddle and a perforated steam pan were stored in that space. *The particle board under the sink had completely disintegrated, leaving behind a mound of black, damp, musty-smelling powdered wood and exposed sub-floor. 12. Follow-up interviews with dietary manager L were attempted on [DATE], but he was not available. 13. Review of the provider's [DATE] Food Storage policy revealed: *Policy Statement: Food storage areas are maintained in a clean, safe, and sanitary environment. *Procedure: -1. Food storage areas are kept clean at all times. -2.Packaged food, canned foods, or food items stored are kept clean and dry. -3. Dry, bulk foods, (flour, sugar, dry beans, food thickener, spices, etc.) are stored in seamless metal or plastic containers with tight fitting covers or in bins that are easily sanitized. It is recommended that foods in bins (e.g. flour or sugar) be removed from original packaging. Scoops are not stored in direct contact with food. Do not add more product to a bin container until it is empty and sanitized. -4.Empty food cans are not reused. -5. Foods are dated with month and year of delivery to the Center . -6. Food products are used within one year unless the manufacturer's expiration date is different. - .9. Foods stored in walk-in refrigerators and freezers are stored above the floor on shelves, racks, dollies, or other surfaces to facilitate thorough cleaning . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-10. Opened items have 'use by' dates indicated on them. This 'use by' date may be circled to differentiate it from date received or date opened. May indicate date opened or date prepared if required by your survey agency. -11. The manufacturer's expiration date, when available, is the use by date for unopened items. -12.thawing meats are stored in the refrigerator, preferably on the bottom shelf. Do not store them over ready to eat foods. 14. Review of the provider's [DATE] Glove Use policy revealed: *Policy Statement: Gloves are worn to maintain safe and sanitary food preparation and service. *Procedure: -1. Proper utensils are used for food handling. -2. Bare hand food contact is prohibited. -3. Proper use of gloves: --a. Wash hands thoroughly before and after wearing or changing gloves. Bacteria build up under gloves and are washed away after wearing gloves. --b. Use gloves that fit properly and that are designed for the task being performed. --c. Change gloves periodically to minimize the buildup of perspiration and bacteria. --d. Gloves are single use and thrown away after each task. Change gloves whenever leaving the workstation or changing the type of food being prepared. --e. Change gloves and wash hands after sneezing, coughing, or touching your hair or face with gloved hands. --f. Avoid wearing gloves whenever their use presents a potential safety hazard (near hot equipment where melting may occur, etc.). --g. All foods on tray line are served out with utensils, no bare hand contact. 15. Review of the provider's [DATE] Refrigerator and Freezer Temperatures policy revealed: *Procedure: - .2. Refrigerator/Freezer temperatures are recorded twice a day, once in the morning and once in the evening. 50916

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 50015 Based on interviews, and quality assurance and performance improvement (QAPI) plan policy review, the provider failed to ensure they identified and corrected quality deficiencies when they occurred throughout the facility and that performance improvement projects (PIP) had been thoroughly identified, implemented, monitored, and regarding pressure ulcer prevention and treatment, infection control including enhanced barrier precautions, and pain management. Findings include: 1. Review of the provider's current QAPI PIPs included: -Maintenance projects. -Dietary cleaning, labeling, and dating. -QAPI. 2. Interview on 2/27/25 at 12:58 p.m. with medical director (MD) H revealed: *He was aware some residents had pressure ulcers. *He completed rounds once a month. -He was updated on pressure ulcers during rounds. *His Nurse practitioner would complete rounds opposite of his rounds schedule. -She received information via fax regarding resident skin issues. *He did not know all the details about the facility and their processes. *He attended the facility's QAPI meetings. -He did not create a QAPI plans. -He provided his insight to the facility QAPI team. *He felt the facility's QAPI had improved within the last month and that it was not a priority before. *He observed wounds when he saw the residents. *He was not aware the facility did not have a repositioning policy. *He wanted the residents to have high-quality care. 3. Interview on 2/27/25 at 1:43 p.m. with the director of nursing (DON) A revealed: (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	affect to health outcomes, resident safety, resident autonomy, resident choice, and quality of care. Workgroups address process improvement through corrective action plans and Plan, Do, Study, Act (PDSA) rapid improvement cycle model. *The QAA committee may determine that some concerns are limited in scope and may be effectively corrected through simple process adjustments. These are quick fix items that do not warrant Workgroup or subcommittee development. *The QAPI Plan and revisions are communicated to the governing body, staff, residents and family members with appropriate communication tools. Examples may include a designated QAPI bulletin board for staff, residents and family members, discussion of QAPI activities during all staff meetings and the provision of routine reports to our governing body. *QAA Committee identifies opportunities for improvement: -QAA Committee evaluates ongoing effectiveness of Performance Improvement Plan (PIP). -QAA Committee sets timetable for follow-up review, if necessary. -QAA Committee determines duration of continued monitoring for sustained improvement. -QAA repeats/returns to PDSA if sustained improvement is not achieved.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50916 Based on observation, interview, and policy review, the provider failed to ensure infection control and prevention practices were followed relating to: *One of one registered nurse (RN) (B) who provided wound care treatments for five of seven sampled residents (109, 42, 28, 24, and 10) with ordered wound care treatments. *Two of three certified nursing assistants (CNA) (T, U, and V) who provided direct patient care and catheter care for two of two sampled residents (12 and 109). *Resident care equipment cleanliness in the therapy gym and the whirlpool tub located on the first floor. Findings include: 1. Observation and interview on 2/26/25 at 7:39 a.m. with RN B during resident 109's wound care treatment revealed: *There was no sign that indicated staff needed to use enhanced barrier precautions (EBP) or personal protective equipment (PPE) while providing his care posted outside or inside his room. *She had two adhesive dressings and a hydrocolloid patch (wound healing product) with the date labeled on them laying on a treatment cart. *She performed hand hygiene (HH) with hand sanitizer, applied gloves, picked up the dressings and entered the resident's room. *Resident 109 gave his permission to be observed. *Resident 109 was completely uncovered sitting on a bath chair while CNA T attached a full body mechanical lift (a mechanical lift and sling used to lift a person's full body) and transferred him to the bed. *CNA T was wearing gloves and no other PPE. *While resident 109 was lying in bed, RN B: -Removed the soiled dressing from resident 109's right ankle and discarded it in the garbage can. -Removed her gloves, discarded them into the garbage can, and applied new gloves without performing HH. -Without cleaning the wound, she applied a new adhesive dressing to his right ankle wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Removed her gloves, discarded them into the garbage can, and applied new gloves without performing HH. -Removed the soiled hydrocolloid patch from his second toe on his right foot. -Without cleaning the wound, she applied a new hydrocolloid patch to his stage two pressure ulcer (wound with partial thickness skin tissue loss from prolonged pressure). -Removed her gloves, discarded them into the garbage can, and applied new gloves without performing HH. -Assisted CNA T in rolling resident onto his side, removed the soiled adhesive dressing from his upper middle back, and without cleaning the wound applied a new adhesive dressing to the abrasion. -Discarded the soiled dressing in the garbage can, removed and discarded her gloves, and performed hand hygiene. *She stated the hydrocolloid patch was a big patch that she had cut into tiny pieces to fit onto his toe. She kept the unused patch pieces in the opened patch package in the treatment cart. 2. Observation and interview on 2/26/25 at 7:55 a.m. with RN B while providing resident 42's wound care treatment revealed: *She performed HH, retrieved her wound care and suprapubic catheter (a flexible tubing surgically placed through the abdomen to drain urine from the bladder) care supplies (dressings) from the treatment cart, entered the resident's room, and placed the dressing packages on the bed sheet without a barrier under them next to the resident. *Resident 42 gave his permission to be observed. *RN B put on a gown, mask, and gloves. *She wet a washcloth in the bathroom and placed it on the bed sheet next to the resident along with wet wipes and a skin barrier cream. *After she removed the resident's undergarments, she: -Removed the suprapubic catheter dressing and wiped around the tubing with a wet washcloth. -Removed and discarded her gloves into a garbage can and put on new gloves without performing HH. -Opened the suprapubic catheter dressing, set it on the bed sheet, applied the barrier cream on the resident's skin, and applied the dressing. -Removed and discarded her gloves into garbage can and put on new gloves without performing HH. -Opened the adhesive dressing (to be placed on resident's coccyx (tailbone)), pulled it out of the package and set it on the bed sheet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Labeled the adhesive dressing and put on new gloves without performing HH. -Helped roll the resident onto his side. -Removed the soiled dressing from the resident's coccyx. -Wiped the area with the wet wipes lying on the bed. -Removed and discarded her gloves into the garbage can and put on new gloves without performing HH. -Applied the barrier cream and new patch to his coccyx. *RN B was not aware of the areas underneath his scrotum (skin pouch under the penis) had opened and stated they had been putting a barrier cream on it. *RN B then applied a barrier cream to those open areas. *While performing wound care for his colostomy bag she: -Laid paper towels down onto the resident's lap and placed a black plastic bag on top of them. -Set scissors, wet wipes, a colostomy bag, skin paste, powder, and colostomy adhesive wafer onto the bed sheet without having placed a barrier under those supplies. -Removed the used colostomy bag and cleaned the opening with wet wipes. -Removed and discarded her gloves into the garbage can and put on new gloves without performing HH. -Opened a skin prep wipe and wiped the skin around the colostomy opening. -Applied the powder to the skin, set the powder in the black plastic bag. Resident 42 asked her if it was empty, to which she said, No and removed it from the bag and set it back on the bed sheet. -Measured the colostomy opening, cut the new colostomy adhesive wafer, set it back on the bed, applied the skin paste, applied the wafer to the skin, and attached the new colostomy bag to the wafer. -Discarded the used supplies, set the powder and skin paste on the resident's tray table, removed her PPE, grabbed the powder and skin paste, and exited the room without performing HH. 3. Observation on 2/26/25 at 8:30 a.m. of RN B during resident 28's wound care treatment revealed: *There was signage on his door that he was on EBP and the staff should have worn gloves, gown, and a mask. *She had a medication cup containing a small amount of white cream and a pair of gloves that had been lying on the treatment cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She took those supplies to resident 28's room. *The resident was on EBP, and that required her to put on PPE prior to entering his room. *She placed the medication cup and gloves on the siderail located outside of the resident's room while she put on the PPE. *She put on those gloves and was not observed to have sanitized her hands before she put them on. *With those gloved hands she: -Opened the resident's door and placed the medication cup on the resident's bedside dresser without a barrier under the medication cup. *She had forgotten to put on a mask and had to leave the room to get one. *Without removing her gloves, she opened the door, got a mask, and put it on her face. *She entered the resident's room, and with those same gloved hands she: -Grabbed a package of wet wipes from the resident's roommate's bedside table. -Removed the bed covers off the resident and assisted him with rolling over to his right side. -Exposed and cleansed his bottom area with a wet wipe. -Removed the cream from the medication cup and applied to his bottom and coccyx area. *She removed her gloves and then washed her hands. 4. Observation on 2/26/25 at 11:30 a.m. of RN B during resident 24's wound care treatment revealed: *She removed several supplies from the treatment cart and placed them on top of the treatment cart without a barrier under them including: -Several gauze dressings she had been taken out of a bulk package. -A bottle of wound cleanser and several gloves. -A pair of scissors and a protective dressing. *She gathered those supplies. took them to the resident's room, and laid them on his bed covers without a barrier under them. *The resident was seated in his wheelchair. *She placed a disposable pad underneath his right foot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*On his door he had signage that he was on EBP and required the staff to use PPE when caring for him. *She sanitized her hands prior to putting on gloves, gown, and a mask. -She put on a pair of gloves that had been lying on resident 24's bedcovers. *She: -Removed his sock and ace bandage from his right foot/leg. -Removed a protective dressing from his right ankle. The dressing had a moderate amount of serous sanguineous drainage on it. *The resident had an open wound and a scabbed wound in that area. *She: -Removed her gloves, sanitized her hands, and put on another pair of gloves that had been lying on the resident's bedcovers. -Took the bottle of wound cleanser and moistened the opened gauze that had been lying on top of a dressing package. -Cleansed his wounds with that same gauze. -Took off the gloves and without sanitizing her hands, put on another pair of gloves that had been laying on his bedcovers. -Opened a package that contained a medicated dressing, cut it with the scissors laying on the resident's bedcovers, moistened it with a syringe of saline that was lying on the resident's bedcovers. -Placed that dressing on a foam bordered dressing, and applied it to the wounds on the his ankle. -Removed her gloves, washed her hands, removed her gown and mask, gathered up the rest of the supplies, and placed them on the treatment cart. -Opened the cart and placed the unused pieces of gauze back into the bulk package that contained clean gauze. 5. Interview on 2/26/25 at 11:25 a.m. with RN B regarding the observations above revealed: *There was no designated wound care nurse. *Whomever was assigned on the schedule for that day was responsible for providing the resident's wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She had not had any training on wound care and could not recall having wound care competencies completed. *She: -Confirmed the steps observed above was her usual process for completing the resident's sound care. -Had not considered that process to be wrong or that it could have created the potential for the residents to acquire an infection. *She then agreed her wound care process did not follow appropriate infection control practices and could have created the potential for infection and may have interfered with the wound's healing process. 6. Observation on 2/27/25 at 7:18 a.m. with RN B during resident 10's wound care treatment revealed: *She applied a gown, mask, and gloves. *There was a barrier placed on the resident's tray table with a bottle of hand sanitizer, two unpacked and dated adhesive dressings, a bottle of skin cleanser, Vaseline in a plastic cup, and unpacked gauze. *She removed a box of gloves from the wall organizer and placed it onto the barrier with the wound care supplies. *Resident 10 gave his permission to be observed. *After performing HH she: -Applied gloves, placed a barrier under both of his feet, removed the resident's left sock and soiled dressing. -Discarded her gloves in the garbage can, performed HH, and put on new gloves. -Sprayed the skin cleanser on a piece of gauze, lifted the resident's left heel, dabbed it with the gauze, and set the left heel on his other foot. -Discarded her gloves in the garbage can, performed HH, and put on new gloves. -Lifted the resident's left heel, applied Vaseline, a new dressing, and placed his sock back on. -Discarded her gloves in the garbage can, performed HH, and put on new gloves. -Removed the resident's right sock and soiled dressing. -Discarded her gloves in the garbage can, performed HH, and put on new gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sprayed the skin cleanser on a piece of gauze, lifted the resident's right heel, dabbed it with the gauze, and set the right heel down on the barrier. -Discarded her gloves in the garbage can, performed HH, and put on new gloves. -Lifted the right heel, applied the Vaseline and a new dressing, and his sock. She then removed the barrier from under the resident's feet. -Discarded the extra gauze, removed her PPE, performed HH, gathered the hand sanitizer, wound cleanser, and box of gloves off of the barrier they were on and set them on the treatment cart. *RN B stated she forgot about his abrasion on his coccyx so she would treat that next. *She set a barrier on the tray table, then set the skin cleanser, bottle of hand sanitizer, gauze, and a folded-up barrier on the barrier. *She removed a barrier cream from the treatment cart and placed some of it into a plastic cup, set it on the barrier. *She removed an unopened adhesive dressing from the treatment cart and set it on the barrier. *She removed the adhesive dressing from the package and labeled it with a marker. *After she performed HH, she: -Applied a gown, mask, and gloves, and set the box of gloves from the treatment cart on the barrier. -Lowered the head of the resident's bed, assisted him to roll onto his side, discarded her gloves into the garbage can, performed HH, and put on new gloves. -Removed the resident's incontinence brief and soiled bandage. -Discarded her gloves into the garbage can, set the barrier on the bed and the bottle of skin cleanser and gauze on top of it. -Performed HH and put on new gloves. -Sprayed the skin cleanser on a piece of gauze, dabbed the resident's wound, then removed and discarded her gloves. -Grabbed the new adhesive dressing and barrier cream and set them on the barrier on the bed. -Performed HH and put on new gloves. -Applied the barrier cream, wiped off excess cream from her gloved hands onto the resident's incontinence brief and applied the new dressing to his coccyx. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-With those same gloves, she grabbed the skin cleanser bottle, set it on the barrier on the tray table, re-applied the resident's incontinence brief, and assisted the resident onto his back. -Discarded her gloves in the garbage, performed HH, and put on new gloves, helped the resident reposition and lifted the head of the bed back up. -Removed her PPE, performed HH, grabbed the skin cleanser and box of gloves and set them on the treatment cart. 7. Interview on 2/27/25 immediately following that wound care treatment with RN B revealed: *She would use EBP with residents who had wounds and catheters. *She agreed she should have been using EBP with resident 109 during his wound care treatment. *She agreed she did not perform appropriate HH or infection control practices during her wound care treatments that she provided to residents 109, 42, and 10. 8. Observation on 2/26/25 at 11:20 a.m. with CNAs U and V with resident 12 revealed: *They had prepared to assist resident 12 with her personal cares and to transfer her out of bed. *On her door there had been signage that she was on EBP and the staff had been required to wear gloves, gown, and a mask when assisting her with personal care. *Without sanitizing his hands, CNA U opened the cover of the linen cart and took out several towels. -He placed those clean towels on the handrail outside of the resident's room. *Without sanitizing their hands, they put on gloves, gown, and a mask and entered resident 12's room. *Resident 12 had been awake and lying on her bed. *CNA U placed the towels inside of the resident's sink, turned the water faucet on to moisten the towels and applied cleansing body soap on them. *With those same gloved hands CNA U: -Opened the resident's clothes closet, took out two hanging clothes items, and showed them to the resident for approval. *They had moved the resident's bed, her bedside table, and the mechanical lift. *With those same gloved hands CNA U: -Turned off the water faucet and took the wet towels out of the sink. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Placed them on the bedside table and assisted CNA V with removing the resident's incontinent brief and repositioning her. -Took the towels from the bedside table and washed underneath of the resident's abdominal folds. -Used those same towels to cleanse her perineal area and catheter tubing. -He assisted CNA V in moving the resident to her left side and used those same towels to cleanse her bottom. He then cleaned the catheter tubing again with those same towels. -Assisted CNA V with putting on a clean incontinent brief on resident 12 and rolling her to her back. *The Hoyer (mechanical lift and sling used to move a person's full body) lift. sling was too small and he stated he had to leave the room to get a different one. *He then removed the PPE and left the room without sanitizing his hands. 9. Interview on 2/26/25 at 12:30 p.m. with CNA U regarding the observation above with resident 12 revealed: *That had been his usual process for gathering supplies, putting on PPE, and assisting her with her personal hygiene and catheter care. *He then agreed those practices created the potential for the resident to acquire a urinary tract infection. *He could not recall having had any education or competencies completed for performing appropriate residents' personal hygiene needs. 10. Observations throughout the building on 2/26/25 from 9:04 a.m. to 9:25 a.m. revealed: *In the whirlpool tub room on the first floor: -The rubber bumpers on the whirlpool tub chair were corroded and crumbling apart. It was not a cleanable surface. -There was a buildup of an unidentified brown and yellow substance in the whirlpool tub where the door sealed with the tub. -In one of the drawers in the tub room, there was a scattered variety of soiled hair picks, a gait belt, nail clippers, and fingernail brushes. *In the therapy gym: -There was a buildup of dust, dirt, and unidentified white flakes in the footwells of the NuStep exercise machine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-i) Therapy activities *14) When Enhanced Barrier Precautions are implemented, the Infection Preventionist or designee: -a) Validates protective equipment (i.e., gloves, gowns, masks, etc.) is maintained near the resident's room so that everyone entering the room can access what they need. -b) Posts the appropriate notice on the room entrance door and in the front of the residents' chart so that all personnel will be aware of precautions or be aware that they must first see a nurse to obtain additional information about the situation before entering the room. 14. Review of the provider's updated 4/2018 Handwashing/Hand Hygiene policy revealed: *7. Use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: -b. Before and after direct contact with residents; -c. Before preparing or handling medications; -d. Before performing any non-surgical invasive procedures; -e. Before and after handling an invasive device (e.g. urinary catheters, IV access sites); -g. Before handling clean or soiled dressings, gauze pads, etc.; -h. Before moving from a contaminated body site to a clean body site during resident care/ -i. After contact with a resident's intact skin; -k. After handling used dressings, contaminated equipment, etc.; -l. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; -m. After removing gloves; -n. Before and after entering isolation precaution settings; *8. Hand hygiene is the final step after removing and disposing of personal protective equipment. *9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 15. Review of the provider's updated 4/2012 Charge Nurse Job Description revealed: (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	02/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*h. Assesses and reports changes in resident's condition, including development of pressure ulcers, to physician, the DNS and responsible party, and takes recommendations for nursing action to be implemented. *4. Assesses on a weekly basis via resident rounds the condition of existing pressure ulcer by stage, size (measurements), sites depth, color, drainage, and odor. Reports problems to the DNS; takes necessary follow up action. *9. Observes infection control procedures performed by staff to validate compliance. 16. Review of the provider's updated 4/2012 Director of Nursing Services Job Description revealed: *3. Establishes systems for care planning, including assessments, plan of treatment, objectives and goals, evaluations, and discharge planning. Maintains accurate and timely documentation reflecting same. Coordinates care needs with other departments. *5. Responsible for recruiting, interviewing, hiring, disciplining, coaching, and conducting performance appraisals on assigned units, or delegating to the appropriate individuals. Confers with ED prior to termination of subordinate staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 46453 Based on observation and interview, the provider failed to maintain the walk-in cooler and freezer in a functioning manner that met industry standards. Findings include: 1. Observation and interview on 2/25/25 from 8:28 a.m. to 9:09 a.m. in the kitchen with dietary manager L revealed: *Upon walking into the walk-in cooler and shutting the door, the light from the hallway was clearly visible above the top of the door, indicating the door did not seal properly. -The gap was large enough to poke several fingers through. -There was an abundance of an unidentified black and white fuzzy growth on the walls, door frame, floor, and shelving units that appeared to have been mold. Mold growth in a walk-in cooler could potentially be due to improper temperature control. *There was ice buildup on the ceiling and floor of the walk-in freezer, which indicated improper temperature control. -At the time of the observation, a side panel of the condenser was hanging and not secured to the condenser unit. The condenser was blowing hot air, which was melting the ice buildup on the ceiling and floor. *Interview at that time with dietary manager L revealed that he was aware of the issues in the walk-in cooler and freezer. 2. Follow-up interviews with dietary manager L were attempted on 2/27/25, but he was not available.