DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

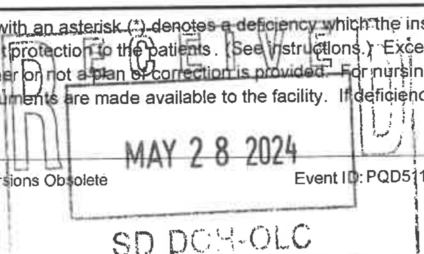
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435088	A. BUILDING ______ B. WING ______	C 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE CARE AND REHAB CENTER INC	500 VERMILLION ST CENTERVILLE, SD 57014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 5/6/24 and again on 5/8/24 Area surveyed was resident abuse. Centerville Care and Rehab Center Inc. was found not in compliance with the following requirement: F600. On 5/8/24: *At 9:10 a.m. administrator A and regional administrator D were given verbal and written notification of the immediate jeopardy identified related to resident abuse by a co-located resident at F600.. *At 11:53 a.m. the removal plan was received. *At 12:20 p.m. the provider's removal plan was accepted. *At 1:20 p.m. while on-site the immediacy was removed. The current resident census: 39 long-term care residents and 6 assisted living residents.	F 000	Centerville Care and Rehab Center understands the severity of this incident and have taken the following actions to provide education to staff and to ensure the safety of our residents.30-minute checks on resident 4 initiated to ensure the safety of all residents. Medical director I discontinued the use of Sildenafil, and will monitor the use of other medications that could lead to sexual temptations. Resident 4 was scheduled to be evaluated by (psychiatry provider) to rule out dementia or other medical conditions that could cause the more frequent sexual behaviors. Resident 4 was seen by (psychiatry provider). No findings from Psychiatrist when evaluated. Resident 4 was evaluated 5/7/24 and will be seen 4 weeks after initial visit. Care plans have been updated. Education was provided to all staff. Managers will provide the education to staff that were not in the building and staff will be required to receive the education before they start their next shift.	5/23/24
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600	All staff will continue to monitor behaviors and safety for all residents. Interventions in place will be assessed and will be modified as needed to make sure the issue is being resolved appropriately. All staff education was provided and documented. Education included information on both incidents so staff are aware of what behaviors have happened and know what to monitor when completing 30-minute checks on Resident 4. Education explained how to intervene if this behavior happens and how to redirect residents if there is a potential interaction with Residents 1, 2, &3. Any Resident that is cognitively impaired or considered vulnerable will monitored the same as Residents, 1, 2, &3. Freedom from abuse, neglect, and exploitation is top priority while caring for all residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Peterson	Adminisitrator	5/23/24

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.



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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review, policy review, and South Dakota Department of Health (SD DOH) facility reported incident (FRI) the provider failed to ensure two of two sampled residents (1 and 2) had been assessed, care plans were updated, and education was provided to staff regarding having been fondled by a co-located resident (4). Findings include: Notice: Notice of immediate jeopardy was given verbally and in writing on 5/8/24 at 9:10 a.m. to administrator A and regional administrator D of the immediate jeopardy related to resident abuse by a colocated resident at F600 when the provider failed to ensure the following: *A resident assessment, care plan updating, and staff education regarding the fondling of vulnerable residents by a co-located resident. On 5/8/24 at 9:10 a.m. administrator A, regional administrator D, and director of nursing (DON) B were asked for an immediate removal plan. Plan: 1."Centerville Care and Rehab Center understands the severity of this incident and have taken the following actions to provide education to staff and to ensure the safety of our residents. May 6, 2024, 30-minute checks on resident 4 initiated to ensure the safety of all residents. Medical director I discontinued the use of Sildenafil, and will monitor the use of other medications that could lead to sexual	F 600	Interdisciplinary team will review care plans, provide education immediately along with documentation of all education provided. Interventions will be started immediately following incident. Comprehensive Care Plan Policy and Abuse and Neglect Policy will be reviewed with all staff so all staff are aware of the steps that needed to be followed when reporting an incident and the importance of reporting immediately. Interdisciplinary team will audit 30-minute checks daily for 4 weeks then weekly for 3 additional months. Interventions will be assessed and modified as needed. Administrator will report findings at monthly QAPI meetings until audit is complete and regulation has been met. Directed In-Service Training will be completed no later then June 6, 2024.	

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F 600	Continued From page 2 temptations. Resident 4 was scheduled to be evaluated by (psychiatry provider) to rule out dementia or other medical conditions that could cause the more frequent sexual behaviors. Resident 4 was seen by (psychiatry provider) 5/7/24. Care plans have been updated. Education was provided to all staff. Managers will provide the education to staff that were not in the building and staff will be required to receive the education before they start their next shift. All staff will continue to monitor behaviors and safety for all residents. Interventions in place will be assessed and will be modified if needed to make sure the issue is being resolved appropriately." On 5/8/24 at 11:53 a.m. the removal plan was received. On 5/8/24 at 12:20 p.m. the provider's immediate jeopardy removal plan was accepted. On 5/8/24 at 1:20 p.m. while on-site the immediacy was removed. Once the immediacy was removed the scope and severity was changed to a "G". Review of SD DOH FRI revealed: *On 5/1/24 at 9:00 a.m. resident 4 was inappropriately touching resident 1 between her legs and she is unable to give consent. *On 5/5/24 at 6:00 p.m. resident 4 had taken resident 2's hand and placed it on his groin. Resident 4 moved resident 2's hand in up and down and rubbing motions. Resident 2 does not talk and cannot defend herself. Interview on 5/6/24 at 9:50 a.m. with registered nurse (RN) E regarding resident 1 being fondled	F 600		

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F 600	Continued From page 3 by resident 4 revealed: *She had observed resident 1 sleeping in a recliner near the front entrance. Resident 4 had his hands on her groin area and was rubbing it. He was moving his tongue back and forth in his mouth while he was rubbing resident 1. *She had observed resident 4 rubbing on other residents' thighs on other occasions. *RN E notified administrator A, DON B, and social services designee C of the witnessed event. Interview on 5/6/24 at 10:10 a.m. with certified nursing assistant (CNA) F regarding resident 4 touching female residents revealed: *She had observed resident 4 touching other residents and reported the incidents to the charge nurse. *She had observed resident 4 touching resident 3's breast and reported the incident to the charge nurse. Interview on 5/6/24 at 10:40 a.m. with CNA G regarding resident 4 touching female residents revealed: *She had observed resident 2 walking past resident 4 in his wheelchair, he then touched her on her buttock. *CNA G reported the incident to the charge nurse. *She had been informed by other staff members resident 4 would touch other residents inappropriately. Interview on 5/6/24 at 11:00 a.m. with RN E regarding CNA's reporting of having been inappropriately touched by resident 4 revealed: *She had received reports by CNAs and informed administrator A, DON B, and social services C of the incidents.	F 600		

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F 600	Continued From page 4 Interview on 5/6/24 at 11:10 a.m. with administrator A, DON B, and social services C regarding the incidents with residents 1, 2, 3 and 4 revealed: *Administrator A had spoken with resident 4 and had contacted the ombudsman. *DON B stated resident 4's son had spoken with him regarding his behavior. *Administrator A had been aware that resident 4 was "targeting" non-consenting residents. *Resident 2's son had been notified of the incident with his mother. Administrator A stated her son was very concerned of his mother's safety. *They had not been aware that resident 3 was touched by resident 4. Review of resident 1's electronic medical record (EMR) revealed: *She had a diagnosis of dementia and psychosis. *On 3/27/24 her brief interview for mental status (BIMS) was 2, indicating severe cognitive impairment. *Resident 1's care plan had not been updated to indicate she had been a victim of inappropriate touching. Review of resident 2's EMR revealed: *She had a diagnosis of dementia, amnesia, and trans ischemic attack (TIA). *On 3/11/24 her BIMS score was 99, indicating the interview assessment is not successful. *Resident 2's care plan had not been updated to indicate she had been a victim of inappropriate touching. Review of resident 3's EMR revealed: *She had a diagnosis of Alzheimer's disease and dementia.	F 600		

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F 600	Continued From page 5	F 600		

*On 3/11/24 her BIMS score was 99, indicating the interview assessment is not successful.
*Resident 3's care plan had not been updated indicate she had been a victim of inappropriate touching.

Review of the provider's June 2021 Abuse and Neglect Policy and Procedure revealed:
*"To ensure that the center has in place and effective system that regardless of the source prevents mistreatment, neglect and abuse of residents of misappropriation of their property."
*"To ensure that resident are not subject to abuse by anyone, including, not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals."
*"To ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated and reported."
*"All staff are responsible for reporting any situation that is considered abuse, neglect, or injury of unknown origin, misappropriation of resident property or involuntary seclusion."
*"The charge nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required, and complete an initial investigation. If this is an injury of unknown origin, the charge nurse will also attempt to determine the cause of the injury. The charge nurse will also ensure that any potential for further abuse is eliminated by taking on of the following actions:
-"If it is resident to resident abuse, the abused resident will be removed to a safe environment."
*"Notification Procedure:"
-"Notify the center administrator immediately of any incident of resident abuse."

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F 600	Continued From page 6 -"Notify the designated agencies in accordance with state law, including the state survey and certification agency." -"If the agencies require an online report to be submitted contact the Social Services Designee, DON, and Administrator." -"Notify the physician and family regarding the facts of the situation. If there is alleged or suspected abuse/neglect or an injury of unknown origin, inform them that an investigation is in process."	F 600		