South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57020	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) COMPLETE DATE
S 000	Compliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 5/6/24 and again on 5/8/24 The area surveyed was resident abuse. Centerville Care and Rehab Center Inc was found not in compliance with the following requirement: S337.	S 000		
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, policy review, record review, and review of the South Dakota Department of Health (SD DOH) facility reported incident (FRI) the provider failed to ensure that one of one sampled resident (1) had care plan revisions to include his sexual behavior with non-consenting co-located residents (3 and 4). Findings include: 1. Review of the SD DOH FRI revealed: *On 5/1/24 at 9:00 a.m. resident 1 had been fondling resident 3 between her legs. -Resident 3 was unable to give consent. *On 5/5/24 at 6:50 p.m. resident 1 had taken resident 4's hand and placed it in his groin area. He then began to move her hand up and down in a rubbing motion in his groin area. -Resident 4 was unable to give consent and defend herself.	S 337	Resident 1 is monitored by 30 minute checks and was evaluated by Rural Psychiatry to rule out dementia or brain disease which may cause sexual behaviors. Per physician order after evaluation, Sildenafil medication has been discontinued. If there is no change in behavior, interventions will be modified to ensure the safety or resident 3 and 4 and ALL other residents in the facility. Education provided to staff about specific incidents. Care Plan Policy was reviewed with care team to ensure care plans are updated if a new focus arises. SSD will monitor care plans to ensure all care plan requirements are met weekly for 4 weeks and then monthly for 3 additional months. SSD or designee will report findings at monthly QAPI meetings until audit is complete and regulation has been met.	5/14/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Peterson — TITLE: Administrator — (X6) DATE: 5/21/24

RECEIVED
MAY 23 2024
SD DOH-OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57020	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) COMPLETE DATE
S 337	Continued From page 1 Interview on 5/6/24 at 9:50 a.m. with registered nurse (RN) D regarding resident 1 fondling resident 3 revealed: *She had observed resident 1 fondling resident 3 between her legs in her groin area. Resident 3 was sleeping in a recliner near the front entrance. *RN D notified administrator A, director of nursing (DON) B, and social services designee C of the incident. Interview on 5/6/24 at 10:10 a.m. with certified nursing assistant (CNA) E regarding resident 1 touching co-located residents revealed she had observed resident 1 touching other co-located residents and she would have reported that to the charge nurse. Interview on 5/6/24 at 10:40 a.m. with CNA F regarding resident 1 touching co-located residents revealed she had been informed by other staff members that resident 1 would touch other residents inappropriately. Interview on 5/6/24 at 11:10 a.m. with administrator A, DON B, and social services designee C regarding resident 1 touching other co-located residents revealed: *Administrator A had been aware that resident 1 was "targeting" non-consenting co-located residents. *DON B agreed that resident 1 was a "predator" and would wait for staff to leave an area to touch co-located residents who were non-consenting. *Adminstrator A had not taken immediate action until the surveyor entered. Review of resident 1's brief interview of mental status (BIMS) completed on 4/12/24 revealed he had a score of 15, indicating he is cognitively intact.	S 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57020	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) COMPLETE DATE
S 337	Continued From page 2 Review of resident 1's service plan revealed: *On 4/12/24 it had been updated to include: -"Resident has potential for sexual expression outside of marital relationship. Goal for resident to engage in consensual relationships only with respect for resident rights and provided dignity and privacy while remaining open to staff support for ensuring safety and consent as needed. Noted resident interpersonal relationships observed to be non-sexual interactions at this time. Will continue to monitor." *There had not been any update to his service plan to include his sexual behaviors observed on 5/1/24 and 5/5/24. Review of the provider's April 2023 Comprehensive Care Plan and Care Conferences policy revealed: *"The Comprehensive Care Plan will be periodically reviewed and revised by the Care Team after each assessment review. The services provided or arranged by the facility must meet professional standards of quality and will be provided by qualified persons in accordance with each resident's care plan." *"Each resident's care plan will be updated if a goal has been met or if a new focus arises."	S 337		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57020	A. BUILDING: _____ B. WING _____	R-C 06/12/2024

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) COMPLETE DATE
{S 000}	Compliance Statement An onsite revisit survey was conducted from 6/11/24 through 6/12/24 for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for all previous deficiencies cited on 5/8/24. Centerville Care and Rehab Center Inc was found not in compliance with the following requirement: S337.	{S 000}	Resident 4 was constantly observed 6/12/24 until discharged on 6/13/24 Policy created by interdisciplinary team. Education provided to all staff. All staff will monitor potential sexual behaviors of all residents and report to administrator and DON. Administrator will document and report any findings weekly for 4 weeks then monthly for 2 additional months. Administrator will report findings at monthly QAPI meetings until audit is complete. Directed in-service is scheduled for 7/8/24.	7/2/24
{S 337}	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on plan of correction (PoC) review from survey date of 5/8/24, interview, record review, and policy review the provider failed to ensure one of one male resident (4) had not fondled six of six cognitively impaired co-located female residents (1, 2, 5, 6, 7 and 8). Findings include: 1. Interview on 6/11/24 at 1:22 p.m. with administrator A regarding resident 4 revealed the following: *He was on 30-minute checks. *He had seen a psychiatrist in May 2024 and was scheduled on 6/11/24 for another appointment. *He continued to touch women residents. -He had denied touching anyone. *She had considered issuing him a 30-day notice to discharge, but had not done so. 2. Interview on 6/11/24 at 3:07 p.m. with certified	{S 337}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Amanda Peterson | Adminisitrator | 7/2/24

RECEIVED
JUL 02 2024
SD DOH-OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57020	A. BUILDING: _____ B. WING _____	R-C 06/12/2024

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) COMPLETE DATE
{S 337}	Continued From page 1 nursing assistant (CNA) J regarding resident 4 revealed: *He "roamed" the facility freely. *She had not "really" felt that other residents were safe from him. 3. Interview on 6/11/24 at 2:35 p.m. with administrator A revealed: *Resident 4 and resident 6 had a physical relationship. *Resident 6 was able to consent to this relationship as "she makes her own decisions; she would have been able to end the relationship if she wanted to." *Resident 4 had the "right to touch people, it is a human need". *Administrator A was not aware resident 6's Brief Interview of Mental Status (BIMS) score was a 5, which indicated she was severely cognitively impaired, and not able to consent to that relationship. 4. Interview on 6/12/24 at 8:25 a.m. with CNA K regarding resident 4 revealed: *He was usually in his room, when he was not, she tried to monitor him. -If he approached a woman resident, she would re-direct him or remove the woman from the area. -He had attempted to take resident 1 and resident 2 back to his room. *She was not always able to monitor him as she was also taking care of other residents. 5. Interview on 6/12/24 at 8:30 a.m. with CNA L regarding resident 4 revealed the following: *"Last week he tried to corner [resident 8] in the hallway and had touched her. Two other CNAs removed both residents from the area." *He had "targeted" residents 2, 3, and 8.	{S 337}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57020	A. BUILDING: _____ B. WING _____	R-C 06/12/2024

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) COMPLETE DATE
{S 337}	Continued From page 2 *He used to have a relationship with resident 6. *Resident 6 had told her she did not want to continue this relationship. -She had reported this to a nurse but did not remember which one. 6. Interview on 6/12/24 at 8:56 a.m. with an employee, who wished to remain confidential, regarding resident 4 revealed: *She was aware that "last week" resident 4 had "caught" resident 6 at the end of the hallway and she "had tried to get away". *She stated "last week he was patting [resident 1]'s breast." *He also patted resident 6 hand and "she rolled her eyes" and stated to the confidential employee, "Let's get going." -Resident 6 did not want resident 4 in her room any longer. -Resident 4 knocked on resident 6's door whenever he went by it. *The staff tried to do 30-minutes checks, and some tried 15-minute checks on resident 4. -She stated, "He is quicker than we are" and "sometimes we are just too busy [to check on him]". *She stated, "I am frustrated as I don't know how to help the ladies." *Resident 4 moved around the building more during the evenings and nighttime. 7. Interview on 6/12/24 at 9:19 a.m. with social service designee C regarding resident 4: *He was competent and knew right from wrong. *He had previously been prescribed Viagra and that had been discontinued. *He was "touchy-feely" and was always reaching out to touch people. *He had gotten defensive when confronted with his behavior, then had stated "ok, I won't do that	{S 337}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57020	A. BUILDING: _____ B. WING _____	R-C 06/12/2024

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) COMPLETE DATE
{S 337}	Continued From page 3 again. *The city cop had been contacted one time to visit him. -He was embarrassed by this, but that had not stopped him. *She stated, "We have to look out for the other people". *In the last three weeks he had touched the outer legs of women. *She had knowledge that resident 4 had "touched" residents 1 and 2. -Staff had intervened during these incidents. *He had a relationship with resident 6. *Administrator A had notified her on 6/11/24 that he had inappropriately touched resident 7. 8. Interview on 6/12/24 at 10:22 a.m. with registered nurse E regarding resident 4 revealed: *On Memorial Day weekend, she had been notified by CNA's F and G that resident 4 had inappropriately touched resident 8. -She thought she had documented the incident in resident 4's care record. -She thought she had submitted an incident report to the South Dakota Department of Health online. *Staff had monitored resident 4 to ensure he had not inappropriately touched women residents. -She stated, "He triggers to ladies that don't recognize [him] or pay attention, those that can't speak for themselves." 9. Interview on 6/12/24 at 11:01 a.m. via telephone with CNA G regarding resident 4 revealed: *She confirmed that during Memorial Day weekend resident 4 had "trapped" resident 8 in the corner in the hallway. -Resident 8 had tried to get away from him but was unable to until staff assisted her from the	{S 337}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57020	A. BUILDING: _____ B. WING _____	R-C 06/12/2024

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) COMPLETE DATE
{S 337}	Continued From page 4 area. *He was mad when staff intervened and removed resident 8 from the area. *If staff are not "right there, there is the potential for him to inappropriately touch women." 10. Review of a 5/26/24 signed document from CNA's F and G regarding an incident between resident 4 and resident 8 revealed the following: *"[CNA G] and [CNA F]where coming out of [a resident's] room and walking down the hall and we seen [resident 4] down at the end of the 100 hall with the resident [8] at the end of the hall and resident [8] tried to get away from him he kept blocking her wheelchair with his as he was touching between her legs and her breasts and every time she tried to get away he would not let her leave he would move his wheelchair in front of hers and [CNA G] and I ran down the hall and took her away from him and he got mad and moved to let us get her by." 11. Review of resident 4's care record revealed the following: *On 5/6/24 staff were to monitor him every 30-minutes for inappropriate behavior. *On 5/14/24 a CNA had reported to administrator A that he was rubbing his groin area and had attempted to get resident 5's attention. *On 5/18/24 a CNA reported that he was seen rubbing resident 2's leg, and staff had intervened and "told him not to touch other residents in that way." *On 5/27/24 he was sitting in resident 6's room next to her. *Resident 6 was in her recliner. -Staff entered the room and intervened. -"He said that she just needed some help." -Resident 6 stated he was "up to no good." -Staff asked resident 6 if she had invited him into	{S 337}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57020	A. BUILDING: _____ B. WING _____	R-C 06/12/2024

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) COMPLETE DATE
{S 337}	Continued From page 5 her room and she said no. *On 6/1/24 a CNA reported that after supper he had taken his hand and rubbed resident 7's outer leg, the CNA had intervened, he had stopped and returned to his room. *On 6/10/24 a housekeeper had notified administrator A that resident 4 had approached resident 1,while she was sleeping, had touched her leg, and staff had intervened. *On 6/11/24 administrator A had talked to resident 4's son regarding other interventions for his inappropriate touching of female residents. 12. 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	{S 337}		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57020	A. BUILDING: _____ B. WING _____	R-C 06/12/2024

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) COMPLETE DATE
{S 337}	Continued From page 6 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." -"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."	{S 337}		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57020	A. BUILDING: _____ B. WING _____	R-C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE CARE AND REHAB CENTER, IN	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) COMPLETE DATE
{S 000}	Compliance Statement A second onsite revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 7/10/24 for deficiencies cited on 6/12/24. All deficiencies have been corrected, and no new noncompliance was found. Centerville Care and Rehab Center Inc is in compliance with all regulations surveyed.	{S 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE