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 _____	04/30/2024

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 recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/28/24 through 4/30/24. Centerville Care and Rehab Center Inc was found not in compliance with the following requirements: F761 and F851.	F 000		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, and policy	F 761	Expired medications for residents: 10,17, 22,7 have been removed and a policy has been created to ensure routine destruction of expired medications. Expiration dates are checked before medication is administered and ALL medications checked a monthly medication exchange. Policy created DON provided education on 5/20/24. DON or designee will monitor all expired medications are removed and/or destructed after monthly pharmacy medication exchange for 3 months then additional months as needed until regulation is met. DON or designee will report findings at monthly QAPI meetings until audit is complete and regulation has been met.	5/2[illegible]/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Amanda Peterson

TITLE: Administrator

(X6) DATE: 5/31/24

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 761	Continued From page 1 review, the provider failed to ensure as needed (PRN) medications stored in blister pack cards with pharmacist determined expiration dates had been monitored for expiration and removed for destruction for four of four sampled residents (7, 10, 17, and 22) in two of two medication carts (100/200 and 300/400). Findings include: 1. Observation and interview on 4/30/24 at 9:30 a.m. with registered nurse (RN) F of the medication carts revealed the 100/200 medication cart had PRN blister-pack cards (med card) with expired medications for three residents (10, 17, and 22): *Resident 10's meclizine was dispensed from the pharmacy on 1/27/22 and expired on 1/27/23. *Resident 17 had three expired medications: -Fludrocortisone was dispensed from the pharmacy on 5/25/22. --The front of the med card had an expiration date of 5/25/23. --The back of the med card had a handwritten expiration date of 9/2022. --When RN F was asked why there were two expiration dates she stated she did not know. -Quetiapine fumarate had been dispensed on 5/25/22 and expired on 5/25/23. -Butalb-acetamin-caff had been dispensed on 5/25/2022. --The expiration date on the front of the card had been crossed off. --The back of the med card had a handwritten expiration date of 12/2022.	F 761		

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F 761	Continued From page 2 *Resident 22 had three expired medications: -Senna-Plus was dispensed on 11/9/2022 and expired on 11/8/2023. -Acetaminophen was dispensed on 12/4/2022 and expired on 11/26/23. -Melatonin was dispensed on 11/9/22 and expired 10/31/2023. 2. Observation of the 300/400 medication cart revealed: *Resident 7's ibuprofen was dispensed on 3/20/2023. -The back of the med card had a handwritten expiration date of "12/23". 3. Continued interview on 4/30/24 at 9:45 a.m. with RN F regarding the expired medications revealed: *She was aware the medications in the med cards expired within one year after they were placed in the med card or earlier if the pharmacist determined it was required. *She did not know who was responsible for monitoring and removing outdated medications in the med cards. 4. Interview on 4/30/24 at 12:45 p.m. with director of nursing (DON) B regarding the expired medications in the above blister packs revealed: *She believed the PRN med cards were monitored and expired medications were disposed of by the pharmacist each time the medication changeover was done. *She contacted the pharmacist and he informed her the consultant pharmacists could check for expiring medications if the provider had requested it, but the pharmacist had not been	F 761		

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F 761	Continued From page 3 checking for outdated medication. 5. Review of the undated Medication Storage in The Facility policy regarding outdated medications revealed: *Outdated medications were to have been immediately removed from the inventory and disposed of according to the procedures for medication disposal. *Drugs re-packed [such as the med cards] by the pharmacy staff would carry an expiration date. The pharmacist determined the exact date based on a number of factors as well as applicable laws or regulations. *The nurse was to check the expiration date of each medication before administering it. *Medication storage conditions were to have been monitored on a [monthly] basis by [the consultant pharmacist or pharmacy designee] and corrective actions were to have been taken if problems were identified. B. Based on observation, interview, and policy review, the provider failed to ensure medications were stored separately by route of administration (how they enter the body) to minimize contamination for seven of seven sampled residents (2, 20, 27, 30, 35, 37, and 38) in one of one treatment cart. Findings include: 1. Observation and interview on 4/30/24 at 10:50 a.m. with RN F of the treatment cart revealed: *The drawers in the treatment cart had plastic dividers approximately ten inches square. *The dividers: - Were marked with the residents' names. -Had not been further divided to separate the orally administered medication from the externally	F 761	Internal and external medications are stored separately for residents: 2, 20, 27, 30, 35, 37, 38. ALL internal and external medications are stored separately for all residents. Policy created and education provided to staff administering medications by interdisciplinary team on 5/20/24. DON will monitor the storage of internal and external medication to minimize cross contamination. Audit will be completed weekly for 4 weeks and monthly for 2 additional months. DON or designee will report findings at monthly QAPI meetings until audits are complete and regulation has been met.	

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F 761	Continued From page 4 used medication and treatments. *Resident 2's divider contained antifungal topical cream, diclofenac 1% topical gel, and artificial tears eye drops. *Resident 20's divider contained hemorrhoid ointment, albuterol sulfate inhalation solution used in nebulizer treatments, and Ventolin HFA inhaler. *Resident 27's divider contained artificial tears eye drops, Rhopressa mesylate eye drops for glaucoma, silver sulfadiazine topical cream, and a bottle of oral nitroglycerin tablets. *Resident 30's divider contained diclofenac 1% topical gel, triamcinolone acetonide nasal spray, and albuterol sulfate HFA inhaler. *Resident 35's divider contained ketotifen 0.025% eye drops, Benadryl topical cream, dipropionate 1% topical cream, and Clotrimazole-betamethasone topical cream. *Resident 37's divider contained brimonidine eye drops for glaucoma, dorzolamide HCL/ Timolol eye drops, and hydrocortisone topical cream. *Resident 38's divider contained Calmoseptine topical cream and an albuterol sulfate HFA inhaler. *RN F stated she did not know that the orally administered medications and eye drops were to be stored separately from externally used medications and treatments. 2. Interview on 4/30/24 at 12:45 p.m. with DON B	F 761		

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F 761	Continued From page 5 regarding the separation of the external medications from oral and eye medications confirmed they had not been stored separately but they should have been. 3. Review of the undated Medication Storage in The Facility Policy regarding maintaining a separation between specific medications revealed orally administered medications were to have been kept separate from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, etc. Eye medications were to have been stored separately according to the facility policy.	F 761		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long	F 851	Hours for salaried employees will be added manually to staffing data when reporting. IT was contacted and settings were managed to allow full access to reporting website. Report 1705D Staffing Data Report loaded to verify all staffing requirements are met. Validation report will confirm the uploaded data was accepted and 1705D report will confirm all requirements have been met. Administrator will monitor and review staffing data report and will continuously monitor, after each quarter data is submitted. Policy has been revised and updated. Administrator will report findings quarterly at monthly QAPI meetings for 4 quarters until regulation is met.	5/21/24

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F 851	Continued From page 6 term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by:	F 851		

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F 851	Continued From page 7 Based on Certification and Survey Provider Enhanced Reports (CASPER) data review, staff schedule and timecard review, and interview, the provider failed to ensure Payroll Based Journal (PBJ) (information of the provider's daily staffing hours for the appropriate care of the residents) data was accurately completed prior to submission to the Center for Medicare and Medicaid Services (CMS) for three of four federal fiscal quarters (2, 3, and 4) of 2023 Findings include: 1. Review of the provider's PBJ data submitted to CMS for federal fiscal quarters 2, 3, and 4 of 2023 revealed the data triggered for days of no registered nurse (RN) hours and days without licensed nursing coverage for 24 hours per day: *From January 1, 2023 through September 30, 2023 there were no RN hours reported for: -Four days in January. -Eight days in February. -Eight days in March. -Five days in April. -Ten days in May. -Seven days in June. -Seven days in July. -Five days in August. -Five days in September. *From January 1, 2023 through September 2023, there were no licensed nursing coverage for 24 hours per day reported for: -31 days in January. -28 days in February. -31 days in March. -30 days in April. -31 days in May. -30 days in June. -31 days in July. -31 days in August.	F 851		

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F 851	Continued From page 8 -30 days in September. 2. Review of the provider's 2023 employee staffing schedules and timecards revealed they had RN coverage and licensed nursing coverage 24 hours per day on the dates listed above. 3. Interview on 4/30/24 at 4:42 p.m. with administrator A regarding the PBJ staffing data revealed she: *Stated she was responsible for gathering and submitting the data. *Confirmed the staffing schedules were correct and they had met the requirements to have daily RN coverage and licensed nursing coverage for 24 hours per day. *Was not aware that the staffing data had been inaccurately submitted to CMS. *Believed she had not added two salaried RNs to the staffing report. *Stated the reports were accepted and she did not see any triggers for low coverage.	F 851		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 4/28/24 through 4/30/24. Centerville Care and Rehab Center Inc was found in compliance.	E 000		

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

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Amanda Peterson Administrator 5/21/24

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	435088	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/30/2024**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 4/30/24. Centerville Care And Rehab Center Inc was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with fire drill procedures (inadequate number of required fire drills). Findings include: 1. Record review at 2:21 p.m. on 4/30/24 revealed there was no documentation of	K 712	Cannot correct prior non-compliance of completion of fire drills of each shift. All residents and staff have been affected. A schedule has been made to ensure competition of fire drills for all shifts. At a minimum fire drill will be completed for each shift once per quarter. Administrator, maintenance director, and interdisciplinary team reviewed, revised, and/or created necessary policies and procedures. Maintenance director and/or designee will audit completion of fire drills monthly for 1 quarter and 1 additional quarter. Maintenance director and/or designee will report findings at monthly QAPI meetings.	5/20/24

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

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K 712	Continued From page 1 overnight shift fire drills for quarter four (October, November, December) 2023. Fire drill paperwork for the month of October was not provided when requested. Interview with the administrator that same day confirmed that finding. She was unaware the minimum number of fire drills per the required frequency had not been met for each shift for 2023. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		

South Dakota Department of Health

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	10605	A. BUILDING: _____ B. WING _____	04/30/2024

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/28/24 through 4/30/24. Centerville Care and Rehab Center Inc was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Peterson

TITLE: Administrator

(X6) DATE: 5/21/24