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 05/21/2025

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 5/18/25 through 5/21/25. Centerville Care and Rehab Center Inc was found not in compliance with the following requirements: F641, F657, F725, F812, F851, F880, and F882. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/18/25 through 5/21/25. The areas surveyed were resident safety regarding elopement and an allegation of staff to resident abuse. Centerville Care and Rehab Center Inc was found not in compliance with the following requirement: F609, and was found to have past non-compliance at F689.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609	Unable to timely report the allegation of resident 27 to the Department of Health. DON, Administrator, and Interdisciplinary Team reviewed and revised as necessary the policy and procedure for resident accident and prevention and required nursing facility event reporting form on 6/12/2025.	7/5/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6/24/2025

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 609	Continued From page 1 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint intake review, interview, and policy review, the provider failed to report an allegation of suspected abuse for one of one sampled resident (27). Findings include: 1. Review of a 12/31/24 SD DOH anonymous complaint intake report revealed: *On 12/19/24 the anonymous writer was told by certified nursing assistant (CNA) F that resident 27 was inappropriately touched on the breast by certified medication aide (CMA)/CNA G. *CMA/CNA G tried holding resident 27's hands behind her back. *CNA F had reported the allegations, but thought nothing had been done. 2. Review of resident 27's electronic medical record revealed: *She had a diagnosis of Alzheimer's disease. *Her Brief Interview for Mental Status assessment score was 03 indicating severe cognitive impairment.	F 609	Re-education was provided by the Administrator on 6/12/25 to the IDT regarding reportable events. Social Services Designee will be responsible for completing a reportable events audit on all risk management reports and documentation ensuring accuracy and compliance within facility policy. Audit will be completed weekly for four weeks and monthly for two more months. Social Services Designee or Designee will present findings from the audit at monthly QAPI meetings for review.	

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F 609	Continued From page 2 3. Interview on 5/19/25 at 9:59 a.m. with resident 27's family member revealed: *She had been told of the allegations of suspected abuse. *She did not believe the accusations. *She felt the provider was transparent about their investigation of the allegation. *She thought CMA/CNA G was wonderful, and she was upset he no longer worked at the facility. Interview on 5/19/25 at 1:17 p.m. with CNA F revealed: *ON the morning of 12/19/24, she was assisting resident 27 in getting up and ready for the day. *Resident 27 was lying across the bed with her legs hanging over the side of the bed and her walker in front of her. *Resident 27's brief was not pulled up and her pajama top was off. *CMA/CNA G came into the room to assist with resident 27. -He jumped on the bed. -His leg was across resident 27's body. -He placed his hand on her inner left thigh. -He rubbed her left shoulder area. -He said resident 27 was his girlfriend. -He said, "Let's get you dressed." -CMA/CNA G's hand rubbed along the left side of the resident's breast. *CNA F told CMA/CNA G she would finish with assisting resident 27. *CMA/CNA G then left the room. *CNA F reported the allegation of suspected abuse to registered nurse (RN) H that day. *She reported the allegation to former administrator O on 12/20/24. Interview on 5/19/25 at 3:38 p.m. with RN H revealed:	F 609		

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F 609	Continued From page 3 *CNA F had reported the above allegation of suspected abuse for resident 27 to her on 12/19/24. *She told her to report it to former administrator O as she was in the facility on 12/19/24 per provider's policy. *She had received education regarding abuse and neglect in the summer of 2024. Interview on 5/21/25 at 8:34 a.m. with social services designee (SSD) P revealed: *She or former administrator O complete the state reporting documents for the provider for any concerns with potential abuse or neglect. *She would report any abuse allegations within 24 hours to SD DOH, law enforcement and ombudsman. *If immediate jeopardy she would report within two hours to the state. *She assumed former administrator O had completed the initial report to the state as she was who investigated the allegation regarding resident 27 in December 2024. *SSD P stated she was not involved in the investigation for the above allegation regarding resident 27. Interview on 5/21/25 at 8:45 a.m. with director of nursing (DON) B revealed: *She was notified of the above allegation regarding resident 27 on 12/23/24 by former administrator O. *She became involved in the allegation investigation by conducting interviews with CNA F and CMA/CNA G on 12/23/24. *CMA/CNA G was suspended during investigation. *She assumed the state report had been completed on 12/20/24 when CNA F reported it to	F 609		

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F 609	Continued From page 4 former administrator O. *Investigation was inconclusive in findings of allegation of abuse. Interview on 5/21/25 at 9:21 a.m. with emergency permit holder (EPH) administrator A revealed: *She was hired on 1/20/25. *She expected allegations of abuse to be reported to SD DOH within 24 hours, and if there were immediate concerns to the resident those should have been reported within two hours. *She confirmed allegation should have been reported. *She and SSD P complete the state reporting for the provider. 4. Review of the provider's revised 5/20/24 Abuse and Neglect Policy and Procedure revealed: *"b. Notify the designated agencies in accordance with state law, including the state survey and certification agency. You may need to notify more than one agency in order to fulfill federal and state regulations. If the agencies require an online report to be submitted contact Social Services Designee, DON, or the Administrator." *"8. The social worker will report the results of all investigation to the state agency and other officials within five (5) working days of the incident, unless otherwise specified by state law, whichever is stricter."	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must	F 641	Administrator, MDS Coordinator, and DON reviewed the Med Classification Policy and Procedure provided by Consultant Pharmacy on 6/16/25.	7/5/2025

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F 641	Continued From page 5 conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, interview and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual review, the provider failed to ensure the Minimum Data Set (MDS) assessments were completed accurately for one of one sampled resident (29) who was not taking a diuretic medication. Findings include: 1. Review of resident 29's electronic medical record (EMR) revealed: *She was admitted on 3/13/21. *There were no current or past medication	F 641	Administrator re-educated MDS Coordinator and DON for proper classification of medications to ensure accurate assessments on 6/16/25. MDS Coordinator modified the assessments on 6/6/2025 for Resident 29 to properly code Enalapril Maleate. All other residents medical records were reviewed and revised to ensure medication orders were accurately assessed. MDS Coordinator to perform weekly audits comparing the MDS Assessments to resident medication lists using the provided policy and RAI 3.0 manual on 10 residents weekly for four weeks and then 10 additional residents monthly for two months. MDS Coordinator or Designee will present findings from the audit at monthly QAPI meetings for review.	

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F 641	Continued From page 6 physician's orders that indicated she received a diuretic (medication to reduce excess body fluid) medication. *Her 6/13/24 Quarterly MDS assessment, section N (medications) indicated the resident was taking a diuretic medication. *Her 9/6/24 Annual MDS assessment, section N (medications) indicated the resident was taking a diuretic medication. *Her 11/30/24 Quarterly MDS assessment, section N (medications) indicated the resident was taking a diuretic medication. *Her 2/23/25 Quarterly MDS assessment, section (medications) indicated the resident was taking a diuretic medication. 2. Interview on 5/20/25 at 1:05 p.m. with MDS Coordinator C revealed: *Resident 29 was prescribed and received Enalapril Maleate (medication to treat high blood pressure). *She reviewed the RAI 3.0 manual and identified Enalapril Hydrochlorothiazide (a combination medication for high blood pressure and a thiazide diuretic) was on the list of diuretics to code in the MDS assessment if received by a resident. *She thought those two medications were the same. *She agreed that resident 29 was not currently receiving a diuretic medication as she received Enalapril Maleate, not Enalapril Hydrochlorothiazide. *She agreed upon further review of discontinued and completed medications orders that resident 29 had not received a diuretic for the last year and MDS assessments were not completed accurately. Interview on 5/20/25 at 3:02 p.m. with director of	F 641		

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F 641	Continued From page 7 nursing (DON) B revealed: *She reviewed resident 29's medication list for the last year and confirmed that there was no physician ordered diuretic medication. *After review of resident 29's MDS assessments completed in the last year, she agreed that the resident's diuretic use had been checked in the MDS assessments in error. 3. Review of the CMS Long-Term Facility RAI 3.0 User's Manual Version 1.19.1 October 2024, section N, Page N7 and N8 revealed: *"Steps for Assessment: -1. Review the resident's medical record for documentation that any of these medications were received by the resident and for the indication of their use during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). -2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room)."	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657	Signage for EBP (Enhanced Barrier Precautions) was put in place by Administrator and MDS Coordinator for Resident 1, 5, 25 and all other qualifying residents on 5/29/25. Resident 1, 5, and 25's care plan will be updated to include the use of EBP when performing catheter and/or wound care. All other residents' care plans will be reviewed and revised to include the use of EBP when performing catheter and/or wound care.	7/5/2025

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F 657	Continued From page 8 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review the provider failed to ensure resident care plans had been revised to reflect their current needs for three of three sampled residents (1, 5 and 25) that required the use of Enhanced Barrier Precautions (EBP) for catheter care and/or wound care. Findings include: 1. Observation and interview on 5/19/25 at 1:09 p.m. with resident 1 in his room revealed: *He had a suprapubic catheter (a tube surgically placed in the bladder through the abdomen to drain urine). *He had wounds to his coccyx (tailbone) and buttock. *There was no personal protective equipment (PPE) such as gowns, available for use in his room. *He stated staff wore gloves, but no gowns when they emptied his catheter and when completed	F 657	The Wound Care, Catheter Care, and Leg Bag policy reviewed and revised by MDS Coordinator and IDT on 6/13/2025 to include EBP language. CNA R, MDS Coordinator C, DON will be re-educated by the Administrator or designee for the proper use of EBP when performing catheter and/or wound care for residents. All other staff responsible for performing catheter and/or wound care for residents will be re-educated by the Administrator or designee. Re-education will include, but not limited to, EBP training through the Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) provided by the CDC. DON or designee will audit the EBP signage, ensuring staff are correctly using EBP when performing catheter and/or wound care weekly for four weeks and monthly for two more months. Designee will present findings from the audit at monthly QAPI meetings for review.	

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F 657	Continued From page 9 his wound care. *There was no signage in his room for EBP. 2. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted on 7/16/2012. *His Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated he was cognitively intact. *He had acquired a wound on 3/3/25 to his right inner gluteus (buttock) fold. *He had acquired a wound on 3/3/25 to his coccyx (tailbone). *He had a suprapubic catheter that was to be changed every two weeks. *His current care plan had a focus area of: "I have a Suprapubic Catheter created on 10/3/2013 with several interventions. *His care plan had a focus area of: "I have pressure ulcers r/t Immobility with new diagnosis of Chronic Multifocal Osteomyelitis (bone infection) Unspecified Femur initiated on 5/9/25 with several interventions. -He had a wound that was positive for Methicillin-resistant Staphylococcus aureus (a type of staph bacteria that's resistant to many antibiotics) on 1/31. *He was treated with an antibiotic and "universal precautions (standard infection control practices that treat all human blood and certain body fluids) were to be used by staff when they were working with his wound area." -Addressed his catheter and wound care needs, but it did not include EBP was required when staff provided his catheter and wound care. 3. Interview on 5/20/25 at 4:04 p.m. with licensed practical nurse (LPN) D revealed: *She received education on using EBP for	F 657		

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F 657	Continued From page 10 resident's 1 and 5. *Staff knew which residents required the need to wear gowns for cares such as, catheter, and wound care. *Changes in residents' care needs are passed along during change of shift report. Interview on 5/20/25 at 4:07 p.m. with Minimum Data Set (MDS) Coordinator C revealed: *Resident 1 had Osteomyelitis, and she did some research which stated resident 1 did not need to be on EBP. *She updated the care plans for all residents. *EBP should be included in the care plan for residents with wound care and catheter care needs. Interview on 5/21/25 at 9:00 a.m. with director of nursing (DON) B revealed that MDS Coordinator C was responsible for updating the residents' care plans regarding care provided by the nursing staff. 4. Observation and interview on 5/19/25 at 12:48 a.m. with resident 5 in his room revealed: *He had a suprapubic catheter (a tube inserted in the bladder to drain urine). *Staff wear gloves when emptying his catheter bag and providing his personal cares and sometimes wear gowns but not always. Review of resident 5's EMR revealed: *He admitted on 2/15/21. *His BIMS score was 14 which indicated he was cognitively intact. *He had a suprapubic catheter. Review of resident 5's care plan revealed: *There was a focus area of "I have Suprapubic	F 657		

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F 657	Continued From page 11 Catheter: Neurogenic bladder. Skin breakdown" that was initiated on 2/23/21 and revised on 3/3/21. *The interventions included "My SP catheter requires little care." *There was no documentation in the care plan for the use of EBP while providing catheter bag emptying or catheter cares. 5. Observation and interview on 5/18/25 at 11:00 a.m. with resident 25 in his room revealed: *He had an indwelling catheter (a tube inserted in the bladder to drain urine.) *Staff used gloves when emptying his catheter bag and providing his catheter care. *He did not think staff had worn gowns when completing these tasks. Review of resident 25's EMR revealed: *He was admitted on 3/10/25. *His BIMS assessment score was 15, which indicated that he was cognitively intact. *He had an indwelling catheter. *He had a diagnosis on admission of a urinary tract infection, acute. Review of resident 25's care plan revealed: *A focus area of "I have a Indwelling Catheter r/t surgery of the foreskin r/t (Balanitis [an inflammation of the glans penis])" initiated on 3/21/25. *Interventions included catheter care every shift per facility protocol. *There was no documentation in the care plan for use of EBP while providing catheter bag emptying or catheter cares. 6. Interview on 5/20/25 at 9:19 a.m. with CNA R revealed:	F 657		

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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 657	Continued From page 12 *She provided care for residents 5 and 25. *She described the process for donning EBP when emptying the catheter urine bag or providing cares. *She usually just uses gloves. *She doesn't use PPE when helping resident to transfer with the lift. Interview on 5/21/25 at 3:14 p.m. with MDS Coordinator C revealed: *She did not include use the need for EBP on residents' care plans. *She did not know she should have included it on their care plans. *Staff would know to use it because they had a meeting when the new EBP standards were implemented, and they cover it at their mandatory annual training. *New staff would know because they work with one of the registered nurses (RNs) for several shifts and the RN would tell them. *She is not aware of any signage available or the need to post it. Review of the provider's comprehensive care plan and care conferences policy updated 2/4/25 revealed: **"A comprehensive Care Plan will be developed for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial problems, needs, and/or strengths that are identified in the Comprehensive Assessment. The Comprehensive Care Plan must deal with the relationship of items or services ordered to be provided for (or withheld) to the facility's responsibility for fulfilling other requirements." Review of the provider's catheter care, leg	F 657		

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F 657	Continued From page 13 bag/catheter bag cleaning and storage policy revised on April 2025 revealed: *Procedural steps were included. *It did not address the use of EBP.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure adequate supervision for one of one sampled resident (18) identified at risk for wandering to prevent him from leaving the building without staff knowledge or supervision. Failure to provide supervision while the resident was outside of the building put the resident at risk for potential accident and/or injury. This citation is considered past non-compliance based on the provider's corrective actions implemented following the incident. Findings include: 1. A review of the 5/15/25 SD DOH FRI regarding resident 18 revealed: *He had eloped (left the building without staff knowledge) from the facility without staff	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 14 knowledge or supervision on 5/14/25 at approximately 6:15 p.m. *He had a Brief Interview for Mental Status (BIMS) assessment score of 4, which indicated he had severe cognitive impairment. *He had a history of exit-seeking but had not exited previously without staff supervision. *He frequently believed the building across the road was his hotel or apartment. *Staff believed he was outside for three to four minutes prior to them responding to the door alarm and locating him in front of the building. *He returned to the building with the assistance of staff and their assessment found no harm or injury. 2. Observation and interview on 5/18/25 at 4:45 p.m. with resident 18 in his room revealed: *He was able to answer basic questions but displayed confusion with his responses. *He stated he did not need to call staff for assistance, but he could go to the door and call out for them. *He was unaware that he had a call light to use to call the staff for assistance. *When it was pointed out to him, he was unclear what it was or why to use it. *He was independent in moving around the facility with his walker with a shuffling gait (a walking pattern characterized by dragging the feet instead of lifting them, often with short, quick steps). *He spent most of each day in the dining room near the activities area. *He had no recollection of leaving the building on 5/14/25. Interview on 5/20/25 at 1:27 p.m. with resident 18's spouse revealed:	F 689		

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F 689	Continued From page 15 *She spent Tuesday afternoons with him playing bingo at the facility. *His cognition had continued to decline to the point that she wondered if he had been reading the materials he had with him or was just making the motions. *He often did not interact with her when she was there with him but he would actively participate in an activity. *She felt the facility had enough staff to take care of him. *She was not concerned with the staff's ability to keep him safe after his elopement the week prior. Interview on 5/20/25 with registered nurse (RN) W revealed: *She worked the night shift on 5/14/25 when resident eloped from the facility. *She was in a resident's room when she heard the door alarm sounding. *When it continued to sound, she left the resident's room, checked the alarm panel and proceeded to the front door. *She observed resident 18 walking away on the sidewalk that ran against the front of the building. He was approximately 35 feet from the front door. *She called for staff assistance and with certified nursing assistant (CNA) U, was able to assist resident in returning to the building. *He was assessed and had no injury or indictors of harm from leaving the building unattended. *She estimated he was outside, unsupervised, for three to four minutes. *He had no further exit-seeking behaviors that evening. *She educated the staff working that shift to closely supervise him and to respond to the door alarm immediately if it sounded. *She stated he often looked out the doors but did	F 689		

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F 689	Continued From page 16 not exit the building unattended. *Resident 18 often would get increasingly confused in late afternoon and evening, thinking he needed to get to his apartment. *She felt they had enough staff and interventions in place needed to keep the residents safe. Interview with Director of Nursing (DON) B revealed: *She was notified by RN W of resident 18's elopement on 5/14/25. *She educated RN W on their elopement policy at that time. *Resident 18 was placed on one-hour safety checks after his elopement on 5/14/25. *She spoke with staff throughout the building over the next several days about interventions they could use when resident 18 was confused about needing to leave the building. *She expected all staff to respond to the door alarm if it sounded. *Facility doors were alarmed, but they were not able to add a wander guard system due to the type of wiring at the facility. *A tab alarm (motion alerting device) was not an intervention option for resident 18 due to his mobility and sensitivity to alarms. *Loud noises such as the fire alarm upset him and caused him increased confusion. *She felt that they had interventions and adequate staff to keep residents safe. Interview and record review on 5/21/25 at 10:17 a.m. with emergency permit holder (EPH) administrator A revealed: *Resident 18 had been placed on hourly safety checks following his elopement. *A notice had been posted for staff on 5/18/25 that resident 18 was at risk for elopement.	F 689		

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F 689	Continued From page 17 *Door alarm audits for response to alarms were initiated on 5/16/25 and would continue for three months for timely response to door alarms. *Review of door alarm audits completed from 5/16/25 to 5/21/25 confirmed appropriate staff response with all response times of 62 seconds or less. *Resident 18's care plan had been updated on 5/19/25 to include the hourly safety checks and interventions for exit-seeking behavior. *A staff in-service was held on 5/20/25, where reeducation was provided on caring for residents with unique needs and exit-seeking, along with the elopement and door alarm policies. *Documentation of staff attendance and education materials confirmed that the training has occurred. Review of resident 18's electronic medical record (EMR) revealed: *He was admitted on 6/6/22. *His diagnoses included: -Parkinson's Disease. -Depression. -Unspecified Dementia. *He had a BIMS assessment score of 4. *A wandering risks scale completed on 3/21/25 had a score of 11, which indicated that he was at high risk to wander. *He was placed on one-hour safety checks as an intervention after his 5/14/25 elopement. Review of resident 18's care plan revealed: *A focus area initiated on 5/19/25 "I am a elopement risk/wanderer r/t (related to) history of attempts to leave facility unattended." *The goal initiated that date was "my safety will be maintained through the review date." *Interventions included:	F 689		

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F 689	Continued From page 18 -"Anticipate my needs for going outside." -"If I try to go outside unsupervised, please walk with me until I am ready to return to the facility." -"Answer door alarms promptly." -"Hourly checks." -"Offer diversions, structured activity, food, conversation." Review of the provider's 2/24/24 door alarm policy revealed: *All exit door alarms are to remain on at all times. *It is the responsibility of all staff to answer any sounding alarm and check outside of the door of where the alarm sounded. Review of the provider's elopement policy updated May 2025 revealed: *A definition of elopement as "when a resident who requires supervision leaves the premises or a safe area without authorization and/or any necessary supervision to do so." *The provider "will be responsible for completing an elopement risk assessment to know who is at risk." *Provide appropriate interventions once a residents identified as being at risk for elopement. *Door alarms will be answered promptly. *Staff will investigate why the door is alarming. Based on the above information, non-compliance at F689 occurred on 5/14/25, and based on the provider's implemented corrective action for the deficient practice confirmed on 5/21/25, the non-compliance is considered past non-compliance.	F 689		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		

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F 725	Continued From page 19 §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and Certification and Survey Provider Enhanced Reports (CASPER) reporting data review, the provider failed to ensure their Payroll Based Journal (PBJ) (information of the provider's daily staffing hours for the appropriate care of the residents) had been completed and submitted to the Center for Medicare and Medicaid Services (CMS) for the months of May	F 725	Unable to timely correct past staffing data into PBJ (Payroll Based Journal) entries for Quarter 3, 2024. Unable to correctly prove the 43 days in Quarter 3, 2024 of sufficient nursing coverage without the use of the employee scheduled documentation to verify the past presence of the required staff on duty. All residents have the potential to be affected by this deficient practice. Administrator or designee will re-educate DON B to clock in and out in the facility's payroll system so staffing records can be accurately rolled over to the PBJ system reducing false infractions. Admin or designee will audit the effectiveness of all staffing entries using the CASPER Report 1705D when it becomes available once per quarter for two quarters. Administrator or designee will audit the nursing shifts to ensure the 24 hour licensed nursing coverage in the facility is met weekly for four weeks, and then monthly for two more months. Admin or designee will present the audit findings at the monthly QAPI meetings for review.	7/5/2025

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F 725	Continued From page 20 and June in Quarter 3 of fiscal year (FY) 2024 to support licensed nurse coverage 24 hours a day had occurred. Findings include: 1. Review of the provider's CASPER reporting data revealed that the PBJ data submitted for Quarter 3 of 2024 indicated the provider failed to ensure licensed nursing coverage 24 hours a day from: *May 1 through May 31, for a total of 22 days. *June 1 through June 30, for a total of 21 days. Interview on 5/21/25 at 11:00 a.m. with emergency permit holder (EPH) administrator A revealed: *She was hired at the facility on 1/20/25. *She stated the previous administrator whose employment at the facility ended at the end of December 2024 either had not submitted the PBJ data or had submitted it incorrectly for Quarter 3 of 2024. *She confirmed the submitted Quarter 3 data did not support licensed nurse coverage had occurred 24 hours a day as indicated in the above CASPER reports. *She was not able to document through the payroll data system that the facility had 24 hours of licensed nursing coverage on the above dates as director of nursing (DON) B was responsible for covering any shifts to ensure the requirement was met. *DON B was a salaried employee and had not been required to keep any record of her hours worked. Interview on 5/21/25 at 11:15 a.m. with DON B revealed: *She was responsible for covering any shifts to	F 725		

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F 725	Continued From page 21 ensure the 24 hour licensed nursing coverage in the facility. *She did not keep any record of days and hours she had worked, and she was not required to punch in or out using the facility's timeclock. Review of the payroll data and staff work schedules provided by the facility on 5/19/25 revealed: *Schedules for May and June 2024 showed DON B was scheduled to work one nursing shift on the floor per week. *Payroll data confirmed 24 hours of nursing coverage had occurred on 5/9/24, 5/10/24, 5/17/24, and 5/18/24. *Employee schedules are not acceptable documentation to verify the presence of required staff. Refer to F851.	F 725		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812	Administrator reviewed and revised kitchen cleanliness policy on 6/3/2025. Kitchen Cleanliness checklists have been updated accordingly on 6/9/2025. Dietary Manager reeducated by Administrator on 6/3/2025 regarding Sanitation and Cleaning schedule policy. Cleaning schedules updated with plate storage cabinet, beverage cart, kitchen floor, storage racks, inside of drawers and drawer handles, and refrigerator door cleaning tasks. Cook L and all dietary staff will be re-educated on cleaning schedule by Dietary Manager. Dietary Aide M will be re-educated by Dietary Manager for cleaning of beverage storage cart.	7/5/2025

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F 812	Continued From page 22 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to follow standard food safety practices to ensure one of one kitchen had been cleaned to maintain a sanitary environment to store, prepare, and serve food to residents. Multiple areas within the kitchen appeared unclean. Findings include: 1. Observation on 5/18/25 at 11:30 a.m. of the kitchen revealed: *The plate storage cabinet had dust on top of the cabinet where the plate covers were stored. *The shelves where the dishes had been stored had food debris and stains on the shelves. *The beverage serving cart with prepared residents' beverages on it had food debris and food stains on the shelves. *The kitchen floor, under the stove, and storage racks were soiled with food debris and dirt. *Drawers containing clean utensils had food stains and food debris in them. *The recessed cabinet and drawer handles were soiled with food debris. *The refrigerator door was soiled food debris. 2. Interview on 5/18/25 at 11:50 a.m. with dietary aide M regarding the cleaning of the beverage storage cart revealed the cart should have been cleaned after every use. 3. Interview on 5/18/25 at 1:00 p.m. with cook L regarding the cleaning of the plate storage	F 812	Dietary Manger or Designee responsible to perform cleanliness audits on plate storage cabinet, beverage cart, kitchen floor, storage racks, inside of drawers and drawer handles, and refrigerator door daily for 7 days, weekly for 4 weeks, and monthly for 3 months. Administrator or Designee to present findings at monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	

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F 812	Continued From page 23 cabinet revealed: *The cooks had specific cleaning scheduled tasks for kitchen equipment and the dietary aides had specific cleaning scheduled tasks for the kitchen. *She agreed the plate storage cabinet was not clean, and she was unsure of the last time it had been cleaned. 4. Interview on 5/20/25 at 9:15 a.m. with cook N regarding the kitchen cleaning tasks schedule revealed: *There was a task to clean the inside and outside of the cabinet doors by the cooks. *She tried to keep up with the cleaning of the inside of utensil storage drawers. *Everyone should have cleaned the drawers if they had noticed they were dirty. *She had agreed that placing clean utensils in a dirty drawer would not be sanitary. 5. Interview on 5/21/25 at 1:30 p.m. with dietary manager (DM) K regarding the cleaning of the kitchen revealed: *All staff who worked in the kitchen were responsible for cleaning the kitchen if they had noticed something was unclean. *She agreed there was no scheduled kitchen cleaning task for the inside of drawers and cabinets. *She agreed the cabinet, drawer, and refrigerator handles were unclean. *DM K agreed that if the floors had been observed as dirty, then the cleaning had not been completed. Review of the provider's May 2022 Sanitation and Cleaning schedules revealed: *"It will be the responsibility of the dietary manager (DM) to provide daily, weekly, monthly,	F 812		

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F 812	Continued From page 24 and as necessary cleaning schedules in the dietary areas." *"Each dietary staff person will be responsible for knowing his or her assigned duty and carrying it our during the designated work schedule." *"The DM is responsible for monitoring staff to ensure that cleaning duties are completed satisfactorily and within proper time frames."	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) 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(p)(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 term care facility (for example, housekeeping). §483.70(p)(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	F 851	Unable to timely correct past staffing data into PBJ (Payroll Based Journal) entries for Quarter 3, 2024. All residents have the potential to be affected by this deficient practice. Administrator or designee will re-educate DON B to clock in and out in the facility's payroll system so staffing records can be accurately rolled over to the PBJ system reducing false infractions. Administrator or designee will audit the effectiveness of staffing entries using the CASPER Report 1705D when it becomes available once per quarter for two quarters. Administrator or designee will present the audit findings at the monthly QAPI meetings for review.	7/5/2025

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F 851	Continued From page 25 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(p)(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(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(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: Based on interview and review of Certification and Survey Provider Enhanced Reports (CASPER) reporting data, the provider failed to ensure their Payroll Based Journal (PBJ) (information of the providers daily staffing hours for the appropriate care of the resident)s had been complete and the data had been submitted	F 851		

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F 851	Continued From page 26 to the Center for Medicare and Medicaid Services (CMS) for the months of May and June in Quarter 3 of FY 2024. 1. Review of the provider's CASPER reporting data revealed that PBJ data submitted for the following dates in Quarter 3 2024 demonstrated the provider failed to ensure Licensed Nursing Coverage 24 hours per day: -May 1 through 31 for a total of 22 days. -June 1 through 30 for a total of 21 days. Interview on 5/21/25 at 11:00 a.m. with emergency permit holder administrator A (EPH administrator A) revealed: *She was hired at the facility on 1/20/25. *She was aware that the previous administrator who left at the end of December 2024 had not submitted PBJ data or had submitted it incorrectly. *She was not able to document through payroll data that they facility had 24 hours of licensed nursing coverage on the above dates as DON B was responsible for covering any shifts to ensure they met this requirement. *DON B was a salaried employee and had not been required to keep any record of hours worked. Interview on 5/21/25 at 11:15 a.m. with DON B revealed: *She was aware that the provider had previously failed to submit PBJ data. *She was responsible for covering any shifts to provide 24 hours of licensed nursing coverage. *She did not keep any record of days and hours worked and was not required to punch the timeclock.	F 851		

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F 851	Continued From page 27 Review of the payroll data and work schedules provided by the facility on 5/19/25 revealed: *Schedules for May and June 2024 showed DON B was scheduled for one floor shift per week. *Payroll data confirmed 24 hours of nursing coverage on 5/9/24, 5/10/24, 5/17/24, 5/18/24. *Employee schedules were not auditable (not able to be verified). Review of provider's April 2023 payroll based journal submission procedure policy revised in May 2024 revealed: *"Mandatory submission of staffing information based on payroll data in a uniform format." *"The procedure steps were: -Direct care staffing and census will be collected quarterly and is required to be timely and accurate. Staffing data includes the number of hours paid to work by each staff member each with day within the quarter. -Fiscal quarters were Q1: October 1-December 31, Q2: January 1-March 31, Q3: April 1-June 30, Q4: July 1-September 30. -Ensure all data is accurate and timely, submit electronically to CMS each quarter. -Run validation report to ensure the upload was accepted. -Run 1705D Staffing Data Report to confirm "no triggers" and all staffing requirements are met."	F 851		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880	CNA R and T will be re-educated for the cleaning of shared resident equipment. CNA R will be re-educated for proper hand hygiene during meal service. CNA U will be re-educated for protecting clean linens during transportation.	7/5/2025

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F 880	Continued From page 28 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880	Dietary Aide Q will be re-educated for changing water mugs. CNA S and T will be re-educated for cleaning and sanitizing the whirlpool tub and chair. The tub chair legs will be repaired or replaced to ensure the exposed metal surface is cleanable. All other staff, including, but not limited to, cleaning of resident equipment, proper hand hygiene during meal service, protecting clean linens during transportation, cleaning and sanitizing the whirlpool tub and chair will be re-educated by the DON or designee. All residents have the potential to be affected by this deficient practice. Signage for EBP (enhanced barrier precautions) was put in place by Administrator and MDS Coordinator for resident's 1 , 5, 25 and all other qualifying residents on 5/29/25. Resident 1, 5, and 25's care plan will be updated to include the use of EBP when performing catheter and/or wound care. All other residents' care plans will be reviewed and revised to include the use of EBP when performing catheter and/or wound care.	

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F 880	Continued From page 29 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure staff followed proper infection control practices regarding: *The cleaning of shared resident equipment by two of two observed certified nursing assistants (CNA) (R and T). *Hand hygiene between assisting residents during an observed meal service of one of one CNA (R). *Protecting clean linens from potential contamination during transport by one of one observed CNA (U). *Hand hygiene while changing water mugs for residents by one of one observed dietary aide (Q). *Cleaning and sanitizing the whirlpool tub and chair by two of two CNA's (S and T). *Followed enhanced barrier precautions (EBP)	F 880	The Wound Care, Catheter Care, and Leg Bag policy reviewed and revised by MDS Coordinator and IDT on 6/13/2025 to include EBP language. CNA R, MDS Coordinator C, DON will be re-educated by the Administrator or designee for the proper use of EBP when performing catheter and/or wound care for residents. All other staff responsible for performing catheter and/or wound care for residents will be re-educated by the Administrator or designee. Re-education will include, but not limited to, EBP training through the Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) provided by the CDC.	

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F 880	Continued From page 30 (requires use of gown and gloves with contact care for three of three identified residents (1, 5, and 25). Findings include: 1. Observation on 5/18/25 at 10:19 a.m. revealed: *Certified nursing assistant (CNA) T pushed a stand aid from an unidentified resident's room on the 300 hall. *An unidentified CNA then took that stand aid to another resident's room on the 300 hall. No cleaning of the equipment occurred. Observation and interview on 5/20/25 at 9:36 a.m. of CNA R returning a mechanical lift (lift and sling used to lift a person's full body) from a resident's room on the 300 hall revealed: *She had not cleaned the lift after using it in a resident's room. *They were supposed to clean the shared equipment, such as lifts, between each resident use, but that only occurred with the equipment was visibly dirty or they had time to clean it. *When asked about the cleaning process, she pointed to sanitizing wipes located at the nurses' station and stated after cleaning the equipment of any visible dirt, they are to re-wipe the equipment with a clean sanitizing wipe. Interview on 5/20/25 at 10:25 a.m. with CNA T regarding the cleaning of shared resident equipment revealed staff were to clean the equipment when they were visibly dirty with the sani-wipes located at the nurse's station. Observation of the Super Sani-cloth sanitizing wipes label instructions revealed to "keep the surface wet for the entire two minutes to allow the active ingredients enough time to interact with	F 880	DON or designee will audit the cleaning of resident equipment, proper hand hygiene during meal service, protecting clean linens during transportation, cleaning and sanitizing the whirlpool tub and chair, cleanable surfaces, EBP signage, and ensuring staff are correctly using EBP when performing catheter and/or wound care weekly for four weeks and monthly for two more months. Designee will present findings from the audit at monthly QAPI meetings for review.	

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F 880	Continued From page 31 and kill microorganisms." Interview on 5/20/25 at 3:14 p.m. with Minimum Data Set (MDS) Coordinator C revealed: *Staff were trained at orientation and annually to clean the lift equipment between each resident use with a sani-wipe. 2. Observation on 5/18/25 at 12:24 p.m. of CNA R in the dining room as she was seated at a table between two residents that needed full assistance with eating revealed: *She got up from the table and used her hands and arms to assist another staff member lift a resident in their wheelchair. *She returned to the table and continued to assist the two residents with eating without washing or sanitizing her hands. Interview on 5/20/25 at 9:36 a.m. with CNA R revealed: *She was trained on assisting residents with eating during her orientation. *She confirmed she had not completed hand hygiene after having close contact with another resident before she assisted other residents with eating as observed above. *She should have had hand sanitizer at the table and used it between assisting the residents. Interview on 5/20/25 at 3:14 p.m. with MDS Coordinator C revealed: *Staff were trained on proper hand hygiene during their orientation and annually. *Hand hygiene should have been completed between tasks and resident contact. 3. Observation and interview on 5/20/21 at 2:51 p.m. with CNA U in the 100 hall and 200 hall	F 880		

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F 880	Continued From page 32 revealed: *She had been restocking towels in resident rooms from a portable linen cart. *She was moving the cart through the hall and day room space without the cover in place. *She stated she was supposed to keep the cover over the linens. *She stated she would close the cover of the cart when she stocked linens in the room of a particular resident who had a communicable disease. Interview on 5/20/25 at 3:14 p.m. with MDS Coordinator C revealed she expected the linen carts to be covered at all times, including when transporting between rooms and through a common area of the facility to protect the linens from potential contamination. Review of the provider's 2/28/24 document titled policies and procedures for laundry revealed the transportation of linen and laundry shall be completed with the clean linen storage containers and racks and covered at all times. 4. Observation and interview on 5/20/25 at 9:34 a.m. with dietary aide Q revealed: *She was delivering fresh water mugs to resident rooms on the 300 hallway. *She had a cart with the clean water mugs and a separate cart where she placed the dirty mugs as she removed them from the resident's rooms. *She took a clean mug into the resident's room and returned with the dirty mug. *She did not complete any hand hygiene between handling the clean mugs and the dirty mugs or between resident rooms. *She reported she had received infection control and hand washing education at their staff	F 880		

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F 880	Continued From page 33 meetings. *Her education for passing residents' water mugs was to use separate carts, one for clean mugs and one for dirty mugs. *She was not aware that she should have washed her hands between handling the clean and the dirty mugs. Interview on 5/20/25 at 3:00 p.m. with dietary manager K revealed: *She had recently completed the ServSafe for Food Managers training. *She had not made any changes to the staff's water mug pass process for residents since she started on 9/12/24. *She did not provide any regular training for dietary staff. *Her orientation process for new staff was to work with them for a few days. *She agreed that the current water mug pass process was not sanitary. Review of the provider's 5/2/24 water pass policy revealed: *The purpose was "to provide guidelines for staff and volunteers to ensure contamination does not happen when passing fresh water." *The procedure steps included: -"Take gray (dirty) cart around to collect all dirty mugs from resident rooms and bring to dishwashing room. -Wash hands using hand hygiene procedure. -Take water pass cart around to resident rooms." 5. Observation and interview on 5/20/25 at 10:28 a.m. with CNA T in the shower room revealed: *She worked as the bath aide approximately one day per week. *She cleaned the whirlpool tub and chair by:	F 880		

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F 880	Continued From page 34 -Moving the chair into the whirlpool tub. -Filling the tub with water. -Measuring about a half cup of sanitizing disinfectant in a disposable cup and adding it to the water. -Turning on the whirlpool jets and letting them run for about five minutes. -Draining the tub and rinsing it with the spray wand. *She stated she followed that process when she had completed all of the baths for the day. *In between baths, she would spray the tub and chair with Clorox disinfecting spray, rinse, and dry the chair with a towel. *She did not recall who had trained her on those cleaning techniques. Observation and interview on 5/21/25 at 8:55 a.m. with CNA S revealed: *She cleaned the whirlpool tub and chair by spraying them with the Clorox disinfecting spray, scrubbing them with a towel, let them sit for a few minutes, then sprayed them off with water. *She would wipe the chair seat dry with a towel. *She cleaned the chair legs after all baths had been completed. *She preferred the bleach product above and did not use the sanitizing disinfectant chemical provided by the facility. *She had learned to clean the whirlpool tub and chair from other CNAs. Observation of the tub chair revealed: *The paint on the chair legs was completely chipped away at each end of the legs. *The exposed metal surface was rusted and was an uncleanable. Interview on 5/20/25 at 3:14 p.m. with	F 880		

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F 880	Continued From page 35 (MDS)Coordinator C revealed: *She was responsible for ensuring the whirlpool tub cleaning process was followed by staff. *She was not aware there was a Clorox disinfecting spray in the tub room. *The policy directed staff to use the provided sanitizing disinfectant after every resident bath for proper cleaning and disinfection of the tub. Review of the provider's 2/28/25 policy and procedures for cleaning of the whirlpool tub and shower chair revealed the cleaning procedure steps were: - Place chair in the tub, close and lock the tub door. -Press the tub fill button and turn the temperature control knob all the way to the left to its warmest level to heat the disinfectant solution and maximize its effectiveness. -Remove residue by rinsing the inside tub surfaces with water using the sprayer. -Press the fill button again to turn off the water. -Using premixed Classic whirlpool disinfectant and cleaner in a spray bottle, thoroughly spray the interior of tub and chair. -Use the button on the side of the tub to run disinfectant through the outlets. -Use the long-handled brush to scrub all interior surfaces of the tub and chair. -Let the disinfectant stay visibly wet on the surfaces for 10 minutes. -Remove the plug from the drain. -Spray water from the shower sprayer into both outlets until clear water appears from the inlet. -Visibly check that the tub and chair were effectively cleaned during the disinfecting process. If not, repeat procedure. -At the end of the day, use a towel to wipe off all excess water in tub and chair.	F 880		

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F 880	Continued From page 36 *The whirlpool tub and shower chair were to be disinfected with the above procedure after each resident use. 6. Observation and interview on 5/19/25 at 12:48 a.m. with resident 5 in his room revealed: *He had a suprapubic catheter (tube surgically placed in the bladder through the abdomen to drain urine) and a colostomy. *There was a rack on the inside of the partially opened bathroom door containing personal protective equipment (PPE). *He stated that staff used the gloves when they emptied his catheter and changed his colostomy bag. *Staff wore gowns sometimes when emptying the catheter bag and providing his personal cares, but not always. *There was a sign inside the bathroom door that EBP (requires use of gown and gloves with contact care) was required. Review of resident 5's care plan revealed: *A focus area of "I have Suprapubic Catheter: Neurogenic bladder. Skin breakdown" that was initiated on 2/23/21 and revised on 3/3/21. *The interventions included "My SP [suprapubic] catheter requires little care." *There was no documentation for the use of EBP while providing his catheter bag emptying or his catheter cares. Review of resident 5's Electronic Medical Record (EMR) revealed: 7. Observation and interview on 5/18/25 at 11:00 a.m. with resident 25 in his room revealed: *He had an indwelling catheter (a tube placed in the bladder to drain urine).	F 880		

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(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 880	Continued From page 37 *Staff used gloves when emptying the catheter bag and providing his catheter care. *He did not think staff had worn gowns when completing those tasks. *There was no signage in his room that indicted he was on EBP. Review of resident 25's care plan revealed: *A focus area of "I have an Indwelling Catheter r/t surgery of the foreskin r/t [related to] (Balanitis)" initiated on 3/21/25. *Interventions included catheter care every shift per facility protocol. *There was no documentation in his care plan for the use of EBP while providing his catheter bag emptying or his catheter cares. *There was no signage in his room indicating that EBP should be used when providing catheter cares. Interview on 5/20/25 at 9:19 a.m. with CNA R revealed: *She provided care for residents 5 and 25. *She described the correct process for putting on PPE when emptying the catheter urine bag or providing cares. *She wore gloves but did not always use PPE when emptying or providing cares. *She would not use PPE when helping resident to transfer with the lift. Interview on 5/21/25 at 3:14 p.m. with MDS Coordinator C revealed: *She had not included the use of EBP on residents' care plans. *She did not know she should have included it on residents' care plans. *She thought staff would know to use EBP for some residents because they had a meeting	F 880		

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 05/21/2025

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CENTERVILLE CARE AND REHAB CENTER INC	500 VERMILLION ST CENTERVILLE, SD 57014

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F 880	Continued From page 38 when the new EBP standards were implemented, and they covered it at their mandatory annual staff training. *She felt new staff would know how to use EBP because they work with one of the registered nurses (RNs) for several shifts and the RNs would educate them. *She was not aware of any signage available to post to inform staff or visitors of the need for use of EBP. *They did not have an infection control policy but she had a binder of information she had printed that she had found online. Review of the provider's 4/2025 revised catheter care, leg bag/catheter bag cleaning and storage policy revised revealed: *Procedural steps that included: -"Assemble equipment. -Wash hands." -Five steps for disconnecting, using alcohol swabs, cleaning bag, draining, drying, and storage. -"Wash hands". *Key Points listed were: -"to prevent cross-contamination -to maintain Drainage system -observations of urine -to remove excess urine and minimize bacterial growth, contamination. Do not allow tip of bag to come in contact with any surface." *It did not address the use of EBP. Review of the provider's untitled policy and procedure revised 12/5/24 regarding "maintaining a closed system on all indwelling urinary drainage systems as much as possible and decrease the possibility of catheter associated urinary tract infections" revealed:	F 880		

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	435088	A. BUILDING _____ B. WING _____	C 05/21/2025

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CENTERVILLE CARE AND REHAB CENTER INC	500 VERMILLION ST CENTERVILLE, SD 57014

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F 880	Continued From page 39 *The listed purpose was "Maintaining a closed system on all indwelling urinary drainage systems as much as possible and decrease the possibility of catheter associated urinary tract infections." *The procedure steps included "Correct hand hygiene and Standard Precautions (or appropriate isolation) to be utilized by all trained staff handling and maintaining catheters." 8. Observation and interview on 5/19/25 at 1:09 p.m. with resident 1 in his room revealed: *He had a suprapubic catheter (a tube surgically placed in the bladder through the abdomen to drain urine). *He had wounds to his coccyx (tailbone) and buttock. *There was no personal protective equipment (PPE) such as gowns, available for use in his room. *He stated staff wore gloves, but no gowns when they emptied his catheter and when completing his wound care. *There was no signage in his room for enhanced barrier precautions (EBP). 9. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted on 7/16/2012. *His Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated he was cognitively intact. *He had acquired a wound on 3/3/25 to his right inner gluteus (buttock) fold. *He had acquired a wound on 3/3/25 to his coccyx (tailbone). *He had a suprapubic catheter that was to be changed every two weeks. 10. Interview on 5/20/25 at 4:04 p.m. with licensed practical nurse (LPN) D revealed:	F 880		

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	435088	A. BUILDING _____ B. WING _____	C 05/21/2025

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CENTERVILLE CARE AND REHAB CENTER INC	500 VERMILLION ST CENTERVILLE, SD 57014

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F 880	Continued From page 40 *She received education on using EBP for resident's 1 and 5. *Staff knew which residents required the need to wear gowns for cares such as, catheter, and wound care. *Changes in residents' care needs are passed along during change of shift report. Interview on 5/20/25 at 4:07 p.m. with Minimum Data Set (MDS) Coordinator C revealed: *Resident 1 had Osteomyelitis, and she did some research which stated resident 1 did not need to be on EBP. *EBP should be included in the care plan for residents with wound care and catheter care needs. Interview on 5/21/25 at 7:24 a.m. with emergency permit holder (EMP) administrator A revealed the provider does not have a EBP policy.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and	F 882	MDS Coordinator will complete the 20-hour Infection Preventionist Training course by the CDC. Final test will be scheduled before 7/31/2025. All residents have the potential to be affected by this deficient practice. DON, administrator and interdisciplinary team reviewed and revised as necessary the policy and procedure for the Infection Prevention and Control on 6/16/2025. Administrator or designee will audit the efforts of the required IPCP course to ensure completion and certification weekly for four weeks and monthly for two more months.	7/5/2025

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 05/21/2025

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F 882	Continued From page 41 §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the provider failed to ensure that one of one designated infection preventionist Minimum Data Set (MDS) coordinator C had completed specialized training in infection prevention and control as required by the Centers for Medicare and Medicaid Services (CMS). Findings include: 1. Interview on 5/18/25 at 3:14 p.m. with MDS coordinator C regarding the infection prevention and control program (IPCP) revealed: *She was a licensed practical nurse (LPN) and the designated infection preventionist (IP). *She had been hired by the facility on 11/30/2019. *She was a full-time employee and was responsible for MDS coordination, resident care plan development, restorative therapy, and the IPCP. *She worked two scheduled nursing shifts on the floor per week along with the above duties. *She had not completed the course test required to obtain the IP certification. *She had expressed to the previous administrator that she felt she had too many work responsibilities and was unable to complete the test. *She believed the leadership team was going to get someone else to be the designated infection preventionist in her place. Interview on 5/20/25 at 10:30 a.m. with director of nursing (DON) B revealed: *MDS coordinator C had completed all of the	F 882	Administrator or designee will present the audit findings at the monthly QAPI meetings for review.	

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	435088	A. BUILDING _____ B. WING _____	C 05/21/2025

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F 882	Continued From page 42 training modules to required to take the certification test. *MDS coordinator C had not completed her infection preventionist certification test. *She believed that MDS coordinator C had exceeded the time requirement to take the certification test and she would not be able to take the test without completing the training course again. *She was hoping that a recently hired LPN would consider taking over the IP duties for the facility. Interview on 5/21/25 at 11:00 a.m. with emergency permit holder (EPH) administrator A revealed: *She was hired as an EPH administrator on 1/20/25. *She was aware that MDS coordinator C had not completed her IP certification. *EPH administrator A stated she was responsible for ensuring the training requirement was met. Review of the training module certificates for MDS coordinator C revealed there was no certificate that indicated she had completed the required training.	F 882		

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
	10605	A. BUILDING: _____ B. WING _____	05/21/2025

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CENTERVILLE CARE AND REHAB CENTER INC	500 VERMILLION ST CENTERVILLE, SD 57014

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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 5/18/25 through 5/21/25. Centerville Care and Rehab Center Inc was found not in compliance with the following requirement: S206.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel	S 206	Administrator reviewed and revised the New Hire Orientation process on 6/12/2025 to include the required 12 subjects. Employee D, U and Y and all other qualifying staff members to be re-educated on fire prevention and advance directives. Administrator or Designee to audit five New Hire files for the 12 required subjects weekly for four weeks and 10 files monthly for two more months. Findings from the audit will be presented at monthly QAPI meetings.	7/5/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10605	A. BUILDING: _____ B. WING _____	05/21/2025

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S 206	Continued From page 1 education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure three of three staff (D, U,and Y) reviewed had completed the required training topics. Findings include: 1. Review of licensed practical nurse (LPN) D's education record revealed: *She was hired on 4/2/25. *She had not completed her fire prevention and advanced directive training. 2. Review of CNA U's education record revealed: *She was hired on 3/24/25. *She had not completed her fire prevention and advanced directive training. 3. Review of certified nursing assistant (CNA) Y's education record revealed: *He was hired on 2/10/25. *He had not completed his fire prevention and advanced directive training. 4. Interview on 5/21/25 at 2:30 p.m. with emergency permit holder administrator A regarding the staff's training revealed: *She had been aware that the training topics were required for staff to complete upon hire. *She was unaware that staff had not completed the training.	S 206		

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	435088	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/19/2025

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K 000	INITIAL COMMENTS A recertification survey was conducted on 5/19/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Centerville Care and Rehab Center Inc was found in compliance.	K 000		

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

Bryan Lakeman | Administrator | 6/17/25

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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	435088	A. BUILDING _____ B. WING _____	05/19/2025

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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 on 5/19/25. Centerville Care and Rehab Center Inc was found in compliance.	E 000		

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

Administrator 6/17/25

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.