STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435088	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centerville Care and Rehab Center Inc	500 VERMILLION ST , CENTERVILLE, South Dakota, 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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/1/26 through 9/3/26. Centerville Care and Rehab Center Inc. was found not in compliance with the following requirements: F552, F676, F686, F812, and F882.	F0000		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to implement pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) prevention interventions for one of one sampled resident (26) who developed a pressure ulcer to his left heel after he admitted to the facility on 6/23/26. Findings include: 1. Observation and Interview on 9/1/26 at 1:43 p.m. with resident 26 in his room revealed he had a boot on his left foot, and he stated he had his left foot	F0686	All residents have the potential to be affected by this deficient practice. A facility wide audit of all residents skin initiated and to be completed by 10/3/26. The review will include current skin assessment and pressure injury status, Braden risk assessment, current wound treatment orders, repositioning and offloading interventions and care plan interventions with goals. Pressure Injury Prevention and Management policy will be reviewed and revised as necessary by the Interdisciplinary Team and the Medical Director before 10/3/26. Directed staff Inservice for all nursing department staff regarding pressure injury prevention to be completed by 10/3/26. Nursing staff not in attendance will be educated prior to their next working shift. Resident 26 care plan was reviewed and revised as indicated to include individualized interventions addressing pressure injury prevention and/or treatment. Interventions have been implemented and will be monitored for effectiveness.	10/3/26

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F0686 SS = G	Continued from page 1 amputated. 2. Observation and Interview on 9/2/26 at 3:30 p.m. with resident 26 in his room revealed he had a wound on the bottom of his left heel. The wound was black in color, and the skin was not open. Resident 26 denied pain in that area unless the area was pushed on. He stated he thought he may have had that wound when he resided at his home before he admitted to the facility and he had walked on it and had taken care of it himself. 3. Review of resident 26's electronic medical record (EMR) revealed he admitted to the facility on 6/23/26. His Brief Interview for Mental Status (BIMS) assessment score was a 3, which indicated his cognition was severley impaired. His diagnoses were Dementia (a group of symptoms affecting memory, thinking, and social abilities), Type 2 Diabetes (a condition involving disruptions in how the body regulates blood sugar) with neuropathy (damage or disease affecting the nerves), and acquired deformities of an unspecified foot. His physical nursing data form indicated that it was to be completed within 24 hours of his admission to the facility. The form was signed by DON B but was not dated. The information documented on that form indicated he did not have diabetic foot ulcers, no pressure ulcers, skin redness, or sores. His 6/23/26 baseline care plan (person-centered plan developed and implemented within 48 hours of a resident's admission) did not indicate that resident 26 had any skin concerns, pressure ulcer risks, skin integrity goals, or pressure ulcer interventions such as turn and repositioning, specialty mattress, cushions or wedges, for his wheelchair or recliner, or skin and wound treatments. The baseline care plan was signed by social services (SS) J. A skin wound progress note dated 7/16/25 by registered nurse (RN) M revealed that resident 26's physician was notified that he had an intact blister on his left heel. Resident 26's 7/17/26 physician's order indicated, "Betadine to blister on (L) [left] heel and (L) great toe. Put Mepilex covering on blister, DC [discontinue]	F0686	DON or Designee will audit all residents with active pressure injuries and sample five residents identified as at risk for pressure injury weekly for four weeks and monthly for two months. Pressure injury prevention and management audit will verify skin assessments are completed as required, pressure injury risk is identified, and appropriate interventions are included in the care plan. Administrator or Designee will president findings from these audits to the monthly QA committee meeting for review until the QA committee advises to discontinue monitoring.	

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F0686 SS = G	Continued from page 2 when healed, every morning and at bedtime for blister (L) heel and (L) great toe." He had a 7/29/26 physician's order that indicated: "(L) [left] heel, cleanse with wound cleanser, gauze, soap and water. Apply a betadine moistened 4 [inch] x [by] 4 gauze to the wound bed, cover it with dry gauze, ABD pad [a thick, highly absorbent medical bandage], Kerlix [a woven gauze bandage]. Change BID [twice a day]. Use heel lift boot instead of Rooke boot [specialized medical off-loading device designed to prevent and treat heel ulcers while naturally warming the lower limb to improve circulation] at all times [while he is] in [a] chair and in bed. Follow up in 7 weeks. No tubigrip [an elasticated upport bandage]! The 8/19/26 weekly wound observation tool indicated that resident 26's left heel pressure ulcer was facility acquired and discovered on 7/17/26. The physician was last notified was 8/17/26 and the family was last notified on 8/17/26 that a new bed (air mattress, with bedrail and trapeze bar) was ordered. The resident was on a turning and repositioning routine. The type of wound was documented as a pressure ulcer, and the pressure ulcer was staged originally as a SDTI (suspected deep tissue injury, meaning a purple or maroon localized area of discolored intact skin or blood filled blister due to damge of underlying soft tissue from pressure). The visible tissue area indicated the overall impression of the wound was that it was healing and that eschar covered the entire area. The was no drainage, inflammation, or odor, and the pressure ulcer measurements were 5.3 centimeters (cm) long, width 10 cm wide, with 0 deep. The 8/26/26 weekly wound observation tool indicated the wound clinic was last notified on 8/17/26. The family was updated on 8/26/26 on the resident's continued preventive measures of a special boot and dressing. He continued with the turning and repositioning routine. The wound measurement had not changed, and the overall impression indicated the wound continued to improve. The 9/2/26 weekly wound observation tool indicated there were no new documented pressure ulcer measurements. There was no documented change in the wound treatment.	F0686		

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F0686 SS = G	Continued from page 3 4. Review of the 8/17/26 VA podiatry progress note indicated that resident 26 was seen for a follow up for his unstageable pressure injury (PI, or pressure ulcer). The note included that the resident's wife stated that the PI developed about 2 weeks after he admitted to the nursing home. The left heel pressure ulcer continued to be present, more stable, 100 % (percent) brown eschar, no odor, and no drainage. He was wearing the heel lift boot at all times. The pressure ulcer was unstageable, and its measurements were 3.0 cm long, 6.2 cm wide, and depth was UTD (unable to be determined). The periwound (the zone of healthy skin that immediately surrounds the outer edge or margin of a wound) was pink, with no drainage, and no signs and symptoms of infection. The interventions were to change the pressure ulcer wound dressing and offload (relieve pressure from) the heel. The resident was to return to the clinic in 3 weeks. 5. Interview on 9/2/26 at 3:30 p.m. with licensed practical nurse (LPN) C during resident 26's and certified nursing assistant (CNA) H during resident 26's in his room revealed his heel wound was healing. LPN C was not sure if resident 26 acquired that wound before or after he admitted to the facility. She stated that the wound was eschar (a thick layer of dead, dark, or black tissue called necrotic tissue) and that the current treatment of Betadine (an antiseptic medicine containing povidone-iodine that kills germs and helps prevent skin infections) would dry out the black eschar tissue and the scab would later fall off. LPN C stated that she would not take measurements of the wound at that time, as those measurements were taken weekly. CNA H thought the resident's left heel wound may have been from the shoes he had been wearing when he admitted to the facility, and he did not have the wound when he admitted to the facility. After the wound was discovered, he was given a boot with sheep skin it to wear. She thought that the wound was from pressure on the area when he was lying in bed. 6. Interview on 9/3/26 at 2:55 p.m. with director of nursing (DON) B regarding resident 26's pressure ulcer revealed she explained that it started as a blister, then became a pressure ulcer once it popped open. She stated the resident was a diabetic, and that wound was now a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer. That wound was not there when he admitted to the facility. She stated there were no interventions implemented by the staff to prevent the pressure	F0686		

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F0686 SS = G	Continued from page 4 ulcer from developing after his admission. She acknowledged that the pressure ulcer was avoidable. 7. Review of the provider's 4/1/26 pressure ulcer prevention policy revealed the policy's purpose was to prevent pressure ulcers. The policy equipment list indicated using heel protectors and pressure-reducing devices. The procedure list indicated: "11. The use of an alternating pressure mattress, a pressure-reducing mattress, or to use flotation pads if ordered, and 12. Protect bony prominences with cushions and pads."	F0686		
F0552 SS = E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the resident or resident's representative were informed of the risks versus benefits of medications, to make an informed decision and consent for resident 2's use of anti-anxiety (a drug used to help reduce the symptoms of chronic anxiety and panic) and anti-depressant (a drug used to help relieve symptoms of depression, anxiety disorders, and other health conditions by balancing brain chemicals that affect mood and emotion) medications, resident 17's anti-depressant medication, and resident 24's anti-psychotic (a drug that alters neurotransmitter	F0552	Unable to correct past noncompliance. All residents have the potential to be affected by this deficient practice. Psychotropic medication policy was reviewed and revised by the Administrator, DON, Social Services Designee, and Medical Director. Resident 2, 17 and 24's medical records will be updated to include an informed consent by resident or resident's representative regarding their respective medications. All current residents on psychotropic medications will be reviewed and revised to ensure informed consent before initiation of new psychotropic medications or dosage increase of existing medications for all residents. Education will be provided by the DON or Designee for all licensed nursing staff on the revised policy and use of consent form by 10/18/26. Education will be provided by the DON or Designee to the resident or resident's representative regarding the risks and benefits of psychotropic medications to make an informed decision for the consent or denial before psychotropic medications are ordered.	10/18/26

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F0552 SS = E	Continued from page 5 activity in the brain to reduce symptoms of mental health conditions) medication before they were administered. Findings include: 1. Review of resident 2's electronic medical record (EMR) revealed he admitted to the facility on 1/5/26. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body function), unspecified, dementia (a group of symptoms affecting memory, thinking and social abilities), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. He had a 6/18/26 physician's order for Lorazepam (a medication for short-term relief of anxiety disorders and anxiety-related sleep problems) 0.5 mg (milligrams) tablet to be administered by mouth two times daily related to Alzheimer's disease, unspecified. He had a 6/2/26 physician's order for Mirtazapine (an atypical antidepressant primarily used to treat major depressive disorder) 7.5 mg tablet to be administered by mouth at bedtime related to dementia. There was no documentation that resident 2 or his representative were informed of the risks and benefits of receiving those medications, alternative treatment options, or that they provided their consent before those medications were administered to resident 2. 2. Review of resident 17's EMR revealed she admitted to the facility on 5/12/22. Her diagnoses included cerebral infarction (the death of brain tissue caused by a sudden loss of blood flow and oxygen), unspecified, and hemiplegia (a medical condition that causes total paralysis on one side of the body) and hemiparesis (weakness or partial loss of movement on one entire side of the body) following a cerebral infarction affecting left non-dominant side of her body. She had a 9/9/25 physician's order for Trazadone (a prescription medication to treat major depressive disorder) ½ tablet (25) to be administered by mouth at bedtime for sleep. There was no documentation that resident 17 or her representative were informed of the risks and benefits of receiving that medication, alternative treatment options, or that they provided their consent before that mediation	F0552	DON or Designee will audit for informed consent including risk and benefit education on all new psychotropic medication orders and dosage increases on existing psychotropic medication orders. This audit will be performed weekly for four weeks and monthly for two months. Administrator or Designee will present findings from this audit to the monthly QA committee for review until the QA committee advises to discontinue monitoring.	

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F0552 SS = E	Continued from page 6 was administered to resident 17. 3. Review of resident 24's EMR revealed he admitted to the facility on 2/25/22. His diagnoses included cerebral infarction due to thrombosis of the right middle cerebral artery, and depression (a common and serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities once enjoyed). He had a 2/26/22 physician's order for Aripiprazole (an atypical antipsychotic medication used to treat mental health and developmental conditions) 2 mg tablet to be administered by mouth one time a day for his mood. There was no documentation that resident 24 or her representative were informed of the risks and benefits of receiving that medication, alternative treatment options, or that they provided their consent before that medication was administered to resident 24. 4. Interview on 9/3/26 at 10:23 a.m. with director of nursing (DON) B revealed that she was unaware they needed to provide education to the resident or their representative on the risks versus benefits of receiving a medication before starting the resident on an anti-depressant, anti-psychotropic or anti-anxiety medication. She confirmed there was no documentation that the residents (2, 17, and 24) or those resident's representatives were informed of the risks versus benefits of receiving those medications, other treatment alternatives, or that they provided their consent before those medications were administered to the residents. 5. Interview on 9/3/26 at 12:09 p.m. with administrator A revealed that she was unaware they needed to provide education when an anti-depressant, anti-psychotropic or anti-anxiety medication was started for a resident. She confirmed the provider did not have a form for consent of those medications, but the nurses would inform a resident or their family if a referral was being made for psychiatric counselling was made. 6. Review of the provider's 3/22/26 revised Psychotropic Medication policy revealed, "1. Psychotropic medications are used only when medically necessary to treat a specific, diagnosed condition documented in the resident's medical record…7. All psychotropic medications must have a	F0552		

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F0552 SS = E	Continued from page 7 valid written or electronic order signed by the prescriber." There was no information in the policy regarding education to a resident or a resident's representative.	F0552		
F0812 SS = E	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. §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, record review, and policy review, the provider failed to follow standard food safety practices to ensure that food items were not expired in one of one walk-in refrigerator, and that the dish machine temperatures were followed and maintained according to the manufacturer's instructions for use (MIU) to ensure the dishes were sanitized in one of one main kitchen. Findings include: 1. Observation on 9/1/26 at 9:53 a.m. in the walk-in refrigerator revealed eight cartons of Bobalu strawberries that were ordered on 8/26/26. One carton had moldy strawberries in it. A grocery bag had a container of Nature Sweet Cherub tomatoes and two cucumbers that were mushy and slimy in it.	F0812	The Administrator, Dietary Manager, and Maintenance Staff reviewed and revised the Dishwasher policy and the food storage policy on 9/16/26. Administrator or Designee will reeducate all dietary and maintenance staff regarding monitoring and recording dishwasher temperatures by 10/18/26. The Administrator or Designee will reeducate all dietary staff on proper food storage and sanitation by 10/18/26. Minimum dishwasher sanitation of 50 ppm and temperature checks of 120 degrees Fahrenheit will be recorded 3x daily by the dietary department and audited by the Dietary Manager or Designee three times weekly for two weeks, weekly for four weeks, and monthly for two months. RS 9/30/26 Potentially hazardous foods and produce will be discarded immediately for any old or slimy appearance and all other potentially hazardous foods after three days. The Administrator or Designee will perform this audit twice weekly for four weeks and monthly for two months. Administrator or Designee will present findings from these audits at the monthly QA committee meeting for review until the QA committee advises to discontinue monitoring.	10/18/26

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F0812 SS = E	Continued from page 8 2. Interview on 9/1/26 at 3:09 p.m. with dietary manager (DM) E revealed that the slimy cucumbers in the walk-in refrigerator were placed there by the activity department. The activity department kept a few items in the walk-in refrigerator for cooking demonstrations. She confirmed the strawberries were delivered on the truck on 8/26/26, and the one container of strawberries did have mold growing in it. She expected the dietary staff to go through the walk-in refrigerator weekly and check for items that were past the use-by date or had gone bad. 3. Observation on 9/1/26 at 4:17 p.m. in the main kitchen revealed a clipboard on top of a stainless-steel cart next to the commercial dishwasher. The document on the clipboard was labeled "Dishmachine Temperature Record Form". The form was dated August 2026. The wash temperature on the form stated, "Wash 120 [degrees Fahrenheit], Chem [chemical] Conc. [Concentrate] 100 PPM [parts per million], and final rinse 120 [degrees Fahrenheit]." There were columns for the morning, noon, and evening shifts to document the findings. The form was missing 17 of the 31 wash temperatures for the morning column, and eight of the documented temperatures were below 120 degrees. The chemical concentrate column was missing 16 levels of chemical. The final rinse column was missing 19 final rinse temperatures, and one of those temperatures was documented below 120 degrees. The noon column had 18 missing or below temperatures for the wash cycle, nine missing chemical concentrates, and 13 missing or below final rinse temperatures. The evening column had 18 missing or below temperatures for the wash cycle, 16 missing chemical concentrates, and 16 missing or below temperature final rinse temperatures. 4. Interview on 9/2/26 at 9:38 a.m. with dietary aide G revealed that the dish machine needed to get to 120 degrees to sanitize the dishes. If it did not get to 120 degrees Fahrenheit, she would repeat the cycle until it got to 120 degrees Fahrenheit. She documented the temperatures and chemical levels on the dish machine form. If there was an issue with the dish machine, she would notify the maintenance department. 5. Interview on 9/3/26 at 1:29 p.m. with maintenance person F revealed that he checked the dishwasher temperature monthly. He was unaware of any low temperature readings. He usually had to adjust the temperature down because the water heater would	F0812		

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F0812 SS = E	Continued from page 9 run too hot. 6. Interview on 9/3/26 at 1:55 p.m. with DM E revealed that the optimal temperature for the dish machine was 120 degrees Fahrenheit. She knew some of the dietary staff were not documenting dish machine temperatures and chemical levels. She expected the dietary staff to document the dish machine temperatures and chemical levels. She was unaware some of the temperatures were documented below 120 degrees Fahrenheit. She had educated the dietary staff to run a few cycles before putting dishes through the dish machine to get it up to 120 degrees Fahrenheit. She agreed the documentation for the dish machine temperatures and chemical levels were not adequate. 7. Interview on 9/3/26 at 3:21 p.m. with administrator A revealed she confirmed that the dietary staff should have been documenting dish machine temperatures and chemical levels. She stated that refrigerated foods should not be kept after three days per the facility's policy. 8. Review of the provider's June Dishmachine Temperature Record form revealed the 120 degrees Fahrenheit wash temperature was missing or documented below 120 degrees 42 times, the chemical concentrate was missing 23 times, and the final rinse temperature was missing or documented below 120 degrees 36 times. 9. Review of the provider's July Dishmachine Temperature Record form revealed the 120 degrees Fahrenheit wash temperature was missing or documented below 120 degrees 43 times, the chemical concentrate was missing 27 times, and the final rinse temperature was missing or documented below 120 degrees 42 times. 10. Review of the manufacturer's general operating instructions for the dish machine revealed, "3. To fill with water, push or flip the FILL button. It is recommended that 140 [degrees Fahrenheit] water be used. Report to your supervisor if it is lower than 120 [degrees Fahrenheit] or higher than 160 [degrees Fahrenheit]." 11. Review of the provider's revised February 2026 Food Preparation/Food Storage policy revealed, "5. Expiration dates will be checked on a regular basis	F0812		

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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
F0812 SS = E	Continued from page 10 and food/fluids which have expired will be discarded. Potentially hazardous foods will be discarded after three days in [the] refrigerator." 12. Review of the provider's revised May 2022 Dishwashing policy revealed, "1. Follow the manufacturer's instructions for operation. 2. Turn on machine. 3. Fill with water. 4. Check temperatures for proper temperature wash, [and] rinse cycle. (IF chemicals are used, check level of chemicals with test strips at least once per meal service.)... Low Temp Machine-120 degrees plus 50 ppm of Sodium Hypochlorite (or according to manufacturer's guidelines on label) on dish surface. 5. Record temperature (and/or chemical level) on dishwashing temperature log."	F0812		
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F0676	Administrator and The Interdisciplinary team will review and revise and the Restorative Therapy policy and procedure. The Administrator has initiated a comprehensive restructuring of its ADL and restorative nursing processes to improve consistency, accountability, communication, and oversight of resident functional outcomes. This includes transitioning from paper-based ADL documentation to EMR documentation in Point Click Care. CNA I and LPN D will be re-educated on the updated Restorative Therapy policy and procedure. All nursing staff will also be re-educated on the updated Restorative Therapy policy and procedure. All Residents that had a restorative program designed for them since January 2026 have been updated and entered into PointClickCare. Therapy services were initiated for Resident 32 and will receive an updated restorative program upon therapy discharge. Documentation of participation and refusal will be entered into the EMR. Administrator or Designee will audit four residents weekly for four weeks and five residents monthly for two months for a decline in ADL's, significant changes, restorative program entered into PointClickCare, and ADL program progress/refusals.	10/18/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435088	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2026

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F0676 SS = D	Continued from page 11 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the provider failed to provide restorative therapy to one of one sampled resident (32) who admitted to the facility using her walker to ambulate (walk) and declined to using a wheelchair for ambulation. Findings include: 1. Interview on 9/1/26 at 10:21 a.m. with resident 32 revealed that when she was admitted to the facility, she used her walker, but now she had to use a wheelchair to get around. She preferred to use her walker even if she moved slower with it. She thought she had upset the therapy department when she voiced that information to them. 2. Review of resident 32's EMR revealed she admitted to the facility on 6/18/25. She had a 5/20/26 Brief Interview of Mental Status (BIMS) assessment score of 12, which indicated her cognition was moderately impaired. Resident 32's diagnoses were acute and chronic respiratory failure with hypoxia (a state in which the body's tissue and organs do not get enough oxygen to function properly), macular degeneration (an eye disease that damages the macula, the central part of the retina at the back of the eye that controls sharp, straight-ahead vision), obstructive pulmonary disease, and diastolic congestive heart failure. She had a 3/25/26 physician's physical therapy (PT) and occupational therapy (OT) to evaluate and treat due to "Resident progressively having more and more trouble ambulating on her own. She would like to do some therapy after speaking to her. May we have orders to do PT/OT focus[ing] on leg and arm	F0676	Administrator or Designee will present findings from these audits to the monthly QA committee meeting for review until the QA committee advises to discontinue monitoring.	

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F0676 SS = D	Continued from page 12 strengthening. It would benefit her to work with therapy at least a couple times a week." Therapy meeting notes dated 4/1/26 indicated resident 32 was working on "standing, strengthening, dressing and toileting." Her 4/21/26 physical therapy treatment encounter note ndicated a restorative therapy program was developed. A PT discharge note indicated that once she was standing, the resident would improve her ability to safely ambulate (walk) at least 10 feet in a room, corridor, or similar space with safety during turning, functional posture, continuous steps, and accurate direction of movement using a four-wheeled walker with supervision or touching assistance from the staff. There was a 4/21/26 restorative program referral that indicated resident 32 was on oxygen, and that she was to work on her active range of motion, AROM (active range of motion), and transferring. The activities to be completed were seated lower extremity exercises, go from a seated position to a standing position with her walker three times, and walk to and from the bathroom or in the hall to walker 10 to 20 feet. The goal was to maintain her strength. A 4/21/26 therapy communication note to the restorative therapy staff indicated, "Recommend 1 [staff] assist for transfers to walker and walking to/from bathroom to assist with oxygen tubing safety, and 1 to 2 [staff] assist for in/out bed." 3. Interview on 9/3/26 at 9:03 a.m. with director of therapy L regarding resident 32's therapy revealed resident 32 had admitted to the facility using both a walker and a wheelchair. She stated resident 32 was discharged from physical therapy (PT) to restorative therapy on 4/21/26. She stated she thought resident 32 refused restorative therapy and expected to see those refusals in the restorative notes or that CNA I would have them on paper. 4. Interview on 9/3/26 at 10:22 a.m. with certified nursing assistant (CNA) I revealed she documented the resident's restorative programs. She stated she received the resident's paper therapy orders but if a resident refused restorative therapy, she would	F0676		

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F0676 SS = D	Continued from page 13 throw the resident's restorative therapy order away. She did not document on paper or in the computer if a resident refused that therapy. She looked through her binder but did not find a restorative therapy order for resident 32. She stated that licensed practical nurse (LPN) D oversaw of the restorative therapy program in April 2026. 5. Interview on 9/3/26 at 10:30 a.m. with LPN D revealed resident 32 well could use her walker with the assistance of one staff member when in her room to go to her bathroom. She stated resident 32 refused to come out of her room. LPN D believed resident 32 could start therapy again and that she was a good candidate if she was willing to participate in therapy. LPN D stated she did not work in restorative therapy since April 2026, and she was not aware that CNA I threw away the resident therapy orders if a resident refused therapy. She expected that if a resident refused therapy, it was documented on paper. LPN D thought therapy was discussed at a therapy meeting with resident 32 and a family member, and her family member did not think resident 32 would participate in therapy. Certified medication (CMA)/CNA K worked in restorative therapy and walked residents, and may have documented that resident 32 had refused to walk with her. 6. Interview on 9/3/26 at 10:50 a.m. with CMA/CNA K revealed she did not work in restorative therapy for quite a while. She had worked with resident 32, and the resident refused to participate in therapy, but CMA/CNA did not document resident 32's refusals. 7. Interview on 9/3/26 at 11:25 a.m. with administrator A revealed the facility did not have a restorative therapy policy. The resident's restorative therapy plans were not created in Point Click Care (PCC), their electronic medical record (EMR) system. The information regarding the resident's restorative therapy plans was directed to LPN D, but since LPN D no longer worked in the restorative therapy program, the information was directed to CNA I. 8. Interview on 9/3/26 at 11:56 a.m. with CNA I revealed that she trained at various places for restorative therapy. LPN D had educated her regarding restorative therapy at this facility. She	F0676		

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F0676 SS = D	Continued from page 14 stated that if she had questions regarding a resident's restorative therapy program, she asked LPN D or director of nursing (DON) B. 9. Interview on 9/3/26 at 12:10 p.m. with resident 32 revealed she did not think she ever refused therapy, but thought she upset the therapy department when she told them she admitted to the facility using her walker but was now in a wheelchair. 10. Interview on 9/3/26 at 2:42 p.m. with DON B regarding the restorative therapy program revealed that LPN D had left working in the restorative therapy program and that had left them in "limbo." DON B stated she did not have time to get the program up and running. She expected CNA I to have the resident's therapy information in a binder. She was not aware that CNA I threw away therapy orders if the resident did not participate in restorative therapy. She thought that resident 32 had discussed wanting to do therapy again, but she had some diarrhea, and that had become a safety issue. She acknowledged that resident 32 may have had a mobility decline and that there was no documentation to support that resident 32 had refused restorative therapy.	F0676		
F0882 SS = D	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 §483.80(b)(4) Have completed specialized training in infection prevention and control.	F0882	An Infection Preventionist was hired by the Administrator on 9/17/26 to fulfill the Infection Control duties according to the ICP job description. Infection Preventionist certification was verified upon hire. The ICP job description was reviewed and revised by the Administrator and DON on 9/16/26. All residents have the potential to be affected by this deficient practice. Administrator or Designee will audit compliance of the Infection Preventionist by maintaining ICP training/certification and fulfills the responsibilities laid out in the ICP job description. Audit to be performed biweekly for one month and monthly for two months.	10/18/26

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F0882 SS = D	Continued from page 15 This REQUIREMENT is NOT MET as evidenced by: Based on interview, job description review, and policy review, the provider failed to ensure they had a designated qualified infection preventionist (IP) onsite who was responsible for the facility's infection prevention and control program and activities to prevent and control infections. Findings include: 1. Interview on 9/1/26 at 9:06 a.m. with administrator A revealed there was no designated IP employed at the facility. She stated the previous IP was licensed practical nurse (LPN) D stepped down from the position in June 2026. 2. Interview on 9/3/26 at 3:40 p.m. with administrator A revealed that the previous IP was LPN D, and she worked at the facility as a nurse, and that another staff member, minimum data set (MDS) N was a certified IP who worked remotely and was not availbable onsite. She stated both of those staff members were available to her and director of nursing (DON) B if they had questions regarding the program, but neither of them worked for the facility as the facility's designated IP. She stated she and DON B performed the IP duties, and she was trying to hire an IP for the facility. She acknowledged the facility did not have an IP since June 2026. 3. Interview on 9/3/26 at 3:40 p.m. with DON B revealed that she was helping complete IP duties and that the former IP (LPN D) in could be available to answer questions if she was in the facility when DON B or administrator A had any questions regarding their infection control program. 4. Review of the provider's undated Infection Preventionist job description revealed the IP was responsible for overseeing the facility's infection prevention and control program and promoting a safe environment for the residents, staff, and visitors. The IP's essential duties included: "Monitor and maintain the facility['s] Infection Prevention and Control Program. Conduct infection surveillance and track infections. Monitor compliance with hand hygiene, PPE [personal protective equipment], isolation precautions, and other infection prevention practices. Investigate and report infections and outbreaks as required. Provide infection prevention education to staff. Complete required infection	F0882	Administrator or Designee will present the findings from these audits to the monthly QA committee meeting until the QA committee advises to discontinue monitoring.	

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F0882 SS = D	Continued from page 16 control audits and follow-up. Assist with antibiotic stewardship activities. Maintain required infection prevention records and reports. Collaborate with nursing, dietary, housekeeping, maintenance, and other departments regarding infection prevention. Perform other duties related to infection prevention as assigned." 5. Review of the provider's 2/4/26 Infection Control and Prevention policy revealed the "Infection Preventionist will be responsible for the following: Investigation A. Surveillance a. Systemic data collection to identify, trend and track infection in residents b. Any resident or employee illness should be reported to one of the nurses ASAP [as soon as possible] c. Data will be reviewed monthly at the QI [quality improvement] meeting and again annually B. Outbreak Control a. A system for detection investigation and control of epidemic diseases in the Long Term Care Facility C. Isolation a. An isolation and precautions system to reduce the risk of transmission of infectious agent i. When and how isolation should be used ii. Type and duration iii. Isolation should be as least restrictive as possible b. Circumstances to prevent employees with communicable disease or other infectious state from direct contact with residents or their food."	F0882		

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 9/2/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Centerville Care and Rehab Center Inc was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K321, K712, and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K0321	Unable to correct past noncompliance. The Maintenance Director and Maintenance Assistant will ensure the storeroom door closes and latches completely. Administrator or Designee will educate Maintenance staff on the proper closure of all hazardous areas ensuring doors close and latch completely. Maintenance Director or Designee will audit the closure of doors, at random in the building, once weekly for four weeks and monthly for two months. Administrator or Designee will present findings from these audits to the monthly QA committee meeting until the QA committee advises to discontinue monitoring.	10/18/26

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	09/27/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435088	A. BUILDING **01 - MAIN BUILD...** B. WING	**09/02/2026**

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K0321 SS = D Bldg. 01	Continued from page 1 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain one randomly observed hazardous area (maintenance office/storage room) as required. Findings include: 1. Observation on 9/2/26 at 2:05 a.m. revealed the maintenance/storeroom was over 100 square feet and contained copious combustible items. The corridor door to that room would not close and latch with the operation of the closer as required on three of three attempts. Interview with the maintenance director at the time of the observation confirmed those findings. The deficiency affected one of numerous requirements for hazardous storage rooms.	K0321		
K0712 SS = D Bldg. 01	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 STANDARD is NOT MET as evidenced by:	K0712	Unable to correct past noncompliance. Administrator and Maintenance staff will review the Fire Evacuation policy and procedure and revise as necessary. An educational fire drill will be led by the Maintenance Assistant or Designee using the Fire Drill policy and procedure to ensure hallways are being cleared. Directed staff Inservice to be held regarding the fire evacuation policy and procedure to ensure clearance of hallways. Maintenance Assistant or Designee will audit the clearing of hallways during each scheduled fire drill for the following three months.	10/18/26

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K0712 SS = D Bldg. 01	Continued from page 2 Based on observation and interview, the provider failed to ensure corridors and exit routes on the 100 wing were kept clear of any obstructions to ensure smooth and rapid evacuation during a fire drill or emergency. Findings include: 1. Observation on 9/2/26 at 2:53 p.m. revealed the fire alarm was sounded to initiate a drill for a simulated fire in resident room 102. The staff responding to the simulated fire location did not clear the corridor of obstructions to ensure smooth and rapid evacuation. A wheelchair and linen cart remained in the corridor directly east of the door to room 102, and a dehumidifier was left at the south end outside of room 107. Interview with the maintenance director at the time of the observation confirmed those findings. The deficiency had the potential to affect 100% of the occupants of that smoke compartment.	K0712	Administrator or Designee will present findings from these audits to the monthly QA committee meeting until the QA committee advises to discontinue monitoring.	
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with	K0923	Administrator and DON will review the Proper Storage of Gas Cylinder and Container Storage policy and procedure. Gas cylinders that were improperly stored will be moved to the proper gas storage location across the hall. Gas cylinders will only be stored in the designated oxygen storage room with appropriate signage. Administrator will educate the DON and all other staff responsible for handling gas equipment on the proper storage of gas equipment. Audits regarding proper gas equipment storage to be completed by Administrator or Designee weekly for four weeks and monthly for two months to ensure proper storage of gas equipment in the designated storage room. Administrator or Designee will present findings from these audits to the monthly QA committee meeting until the QA committee advises to discontinue monitoring.	10/18/26

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Centerville Care and Rehab Center Inc	**500 VERMILLION ST , CENTERVILLE, South Dakota, 57014**

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K0923 SS = D Bldg. 01	Continued from page 3 precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to protect medical gas storage as required. Combustible items were stored within five feet of the oxygen (O2) cylinders and the cylinders were not clearly marked as full or empty in one randomly observed location (storage room across the corridor from the O2 closet). Findings include: to 1. Observation on 9/2/26 at 2:37 p.m. revealed combustible materials were stored adjacent to and within five feet of oxygen cylinders in the director of nursing (DON)'s Office across the corridor from the O2 closet. There were five E-sized oxygen cylinders found stored in a plastic cylinder storage rack. Those cylinders were stored directly next to various combustible materials. Additionally, those cylinders were not clearly identified as "full" or "Empty". Both the oxygen storage requirements for being clearly marked and the minimum five feet of separation from combustibles were not maintained as required in this area. Interview with the maintenance director at that same time confirmed that finding. He stated he was unaware those oxygen cylinders were stored in that manner in that location. He further stated he believed the nursing staff likely stored those cylinders there out of convenience due to the limited space in the oxygen storage room directly across the corridor. The deficiency had the potential to affect all	K0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435088	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centerville Care and Rehab Center Inc	500 VERMILLION ST , CENTERVILLE, South Dakota, 57014

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K0923 SS = D Bldg. 01	Continued from page 4 occupants of the smoke compartment	K0923		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435088	A. BUILDING B. WING	09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centerville Care and Rehab Center Inc	500 VERMILLION ST , CENTERVILLE, South Dakota, 57014

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E0000	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 9/2/26 . Centerville Care and Rehab Center Inc was found in compliance.	E0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristi Schmidt	Administrator	09/27/26

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 _____	09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 9/1/26 through 9/3/26. Centerville Care and Rehab Center Inc. was found in compliance.	S 000		

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

TITLE: Administrator

(X6) DATE: 09/27/26