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 ______	R-C 06/12/2024

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

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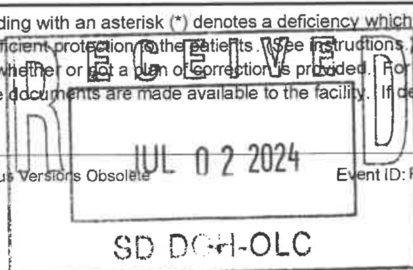
{F 000}	INITIAL COMMENTS An onsite revisit survey was conducted from 6/11/24 through 6/12/24 for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities for all previous deficiencies cited on 5/8/24. Centerville Care and Rehab Center Inc. was found not in compliance with the following requirement: F600. *On 6/12/24 at 11:30 a.m. administrator A was given verbal and written notification of the immediate jeopardy identified related to resident abuse by a co-located resident at F600. On 6/12/24 at 2:55 p.m. the removal plan was received. On 6/12/24 at 5:08 the provider's immediate jeopardy removal plan was accepted. On 6/12/24 at 5:23 while on-site the immediacy was removed. Once the immediacy was removed the scope and severity was changed to a "H". The current resident census: 42 long-term care residents and 5 assisted living residents.	{F 000}	Resident 4 was constantly observed 6/12/24 until discharged on 6/13/24 Policy created by interdisciplinary team. Education provided to all staff. All staff will monitor potential sexual behaviors of all residents and report to administrator and DON. Administrator will document and report any findings weekly for 4 weeks then monthly for 2 additional months. Administrator will report findings at monthly QAPI meetings until audit is complete. Directed in-service is scheduled for 7/8/24.	7/2/24
{F 600} SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	{F 600}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Peterson	Adminisitrator	7/2/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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{F 600}	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on plan of correction (PoC) review from survey date of 5/8/24, interview, record review, and policy review the provider failed to ensure one of one co-located male resident (4) had not fondled six of six cognitively impaired female residents (1, 2, 5, 6, 7 and 8). Findings include: Notice of immediate jeopardy was given verbally and in writing on 6/12/24 at 11:30 a.m. to administrator A of the immediate jeopardy related to resident abuse by a co-located resident at F600 when the provider failed to ensure a co-located male resident had not fondled six co-located female residents who were cognitively impaired. On 6/12/24 at 11:37 a.m. administrator A was asked for an immediate removal plan. Plan: 1."Centerville Care and Rehab Center understands the severity of this incident and will take the following actions to ensure incident will not occur again. Resident [4] will be constantly observed ensuring he will not have access to women in the facility. There will be a staff member constantly monitoring outside his room. If [resident 4] needs to leave his room a staff member will be with him at all times. All staff in the building will be educated and notified that [4] will be constantly observed until he is discharged. [Resident 4] will be discharged from Centerville Care and Rehab Center as soon as placement is found. [Resident 4] will admit to [redacted facility]	{F 600}		

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{F 600}	Continued From page 2 6/13/24 when there is an admitting order. [Resident 4]'s wife is able to move with him as well. There is a schedule of who will be constant observing and staff will be documenting observation. Staff will be educated and notified of constant observation before they start their shift." On 6/12/24 at 2:55 p.m. the removal plan was received. On 6/12/24 at 5:08 p.m. the provider's immediate jeopardy removal plan was accepted. On 6/12/24 at 5:23 p.m. while on-site the immediacy was removed. Once the immediacy was removed the scope and severity was changed to a "H". 2. Interview on 6/11/24 at 1:22 p.m. with administrator A regarding resident 4 revealed: *He was on 30-minute checks. *He had seen a psychiatrist in May 2024 and was scheduled on 6/11/24 for another appointment. *He continued to touch women residents. -He had denied touching anyone. *She had considered issuing him a 30-day notice to discharge, but had not done so. 3. Interview on 6/11/24 at 3:07 p.m. with certified nursing assistant (CNA) J regarding resident 4 revealed. *He "roamed" the facility freely. *He had come to the dining room on his own several times. *Staff had assisted him in his wheelchair back to his room. *She had not "really" felt that other residents were safe from him.	{F 600}		

{F 600} Continued From page 3 {F 600}

4. Interview on 6/11/24 at 3:30 p.m. with resident 6 revealed:
*She felt she had no friends.
*Her brother had visited her often.

5. Interview on 6/11/24 at 2:35 p.m. with administrator A revealed:
*Resident 4 and resident 6 had a physical relationship.
*Resident 6 was able to consent to this relationship as "she makes her own decisions, she would have been able to end the relationship if she wanted to."
*Resident 4 had the "right to touch people, it is a human need".
*Administrator A was not aware resident 6's Brief Interview of Mental Status (BIMS) score was a 5, which indicated she was severely cognitively impaired, and not able to consent to that relationship.

6. Interview on 6/12/24 at 8:25 a.m. with CNA K regarding resident 4 revealed:
*He was usually in his room, when he was not, she tried to monitor him.
-If he approached a woman resident, she would re-direct him or remove the woman from the area.
-He had attempted to take resident 1 and resident 2 back to his room.
*She was not always able to monitor him as she was also taking care of other residents.

7. Interview on 6/12/24 at 8:30 a.m. with CNA L regarding resident 4 revealed:
*"Last week he tried to corner [resident 8] in the hallway and had touched her. Two other CNAs removed both residents from the area."

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*He had "targeted" residents 2, 3, and 8.
*He used to have a relationship with resident 6.
*Resident 6 had told her she did not want to continue this relationship.
-She had reported this to a nurse but did not remember which one.

8. Interview on 6/12/24 at 8:56 a.m. with an employee, who wished to remain confidential, regarding resident 4:
*She was aware that "last week" resident 4 had "caught" resident 8 at the end of the hallway and she "had tried to get away".
*She had overheard resident 8 stating, "Thank you for getting me away from that evil man."
-She was aware that two CNA's had filled out an incident report regarding that incident.
*She stated "last week he was patting [resident 1]'s breast.
*He also patted resident 6's hand and "she rolled her eyes" and stated to the confidential employee, "Let's get going."
-Resident 6 did not want resident 4 in her room any longer.
-Resident 4 knocked on resident 6's door whenever he went by it.
*The staff tried to do 30-minute checks, and some tried 15-minute checks on resident 4.
-She stated, "He is quicker than we are" and "sometimes we are just too busy [to check on him]".
*She stated, "I am frustrated as I don't know how to help the ladies."
*Resident 4 moved around the building more during the evenings and nighttime.

9. Interview on 6/12/24 at 9:19 a.m. with social service designee C regarding resident 4 revealed:
*He was competent and knew right from wrong.

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*He had previously been prescribed Viagra and that had been discontinued.
*He was "touchy-feely" and was always reaching out to touch people.
*He had gotten defensive when confronted with his behavior, then had stated "ok, I won't do that again".
*The city cop had been contacted one time to visit him.
-He was embarrassed by this, but that had not stopped him.
*She stated, "We have to look out for other people".
*In the last three weeks he had touched the outer legs of women.
*She had knowledge that resident 4 had "touched" residents 1 and 2.
-Staff had intervened during these incidents.
*He had a relationship with resident 6, and she "seemed ok with it" and "she acted like she could tell him to go away if she wanted to".
*On 6/11/24 resident 6's psychiatrist had notified her that relationship was not appropriate due to resident 6's BIM's score of 5, and she had a diagnosis of dementia.
-When her power of attorney was notified of this, he wanted the relationship to stop.
*Administrator A had notified her on 6/11/24 that he had inappropriately touched resident 7.

10. Interview on 6/12/24 at 10:22 a.m. with registered nurse E regarding resident 4 revealed:
*On Memorial Day weekend, she had been notified by CNA's F and G that resident 4 had inappropriately touched resident 8.
-She had assessed resident 8 and had not thought she was distressed, and her clothing was not disheveled.
-Resident 8 was mostly non-verbal, but had

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stated she was "ok".
-She had notified director of nursing B of the incident.
-She thought she had documented the incident in resident 4's and 8's electronic medical records (eMAR).
-She thought she had submitted an incident report to the South Dakota Department of Health online reporting system.
*Staff had monitored resident 4 to ensure he had not inappropriately touched women residents.
-She stated, "He triggers to ladies that don't recognize [him] or pay attention, those that can't speak for themselves."

11. Interview on 6/12/24 at 11:01 a.m. via telephone with CNA G regarding resident 4 revealed:
*She confirmed that during Memorial Day weekend resident 4 had "trapped" resident 8 in the corner in the hallway.
-Resident 8 had tried to get away from him but was unable to until staff assisted her from the area.
*He was mad when staff intervened and removed resident 8 from the area.
-Resident 8 had appeared to be distressed.
*If staff are not "right there, there is the potential for him to inappropriately touch women".

12. Review of a 5/26/24 signed document from CNA's F and G regarding an incident between resident 4 and resident 8 revealed the following:
*"[CNA G] and [CNA F]where coming out of [a resident's] room and walking down the hall and we seen [resident 4] down at the end of the 100 hall with the resident [8] at the end of the hall and resident [8] tried to get away from him [resident 4] he kept blocking her wheelchair with his as he

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was touching between her legs and her breasts and every time she tried to get away he would not let her leave he would move his wheelchair in front of hers and [CNA G] and I ran down the hall and took her away from him and he got mad and moved to let us get her by."

13. Review of resident 4's care record revealed the following:
*On 5/6/24 staff were to monitor him every 30-minutes for inappropriate behavior.
*On 5/14/24 a CNA had reported to administrator A that he was rubbing his groin area and had attempted to get resident 5's attention.
*On 5/18/24 a CNA reported that he was seen rubbing resident 2's leg, and staff had intervened and "told him not to touch other residents in that way."
*On 5/27/24 he was sitting in resident 6's room next to her.
*Resident 6 was in her recliner.
-Staff entered the room and intervened.
-"He said that she just needed some help."
-Resident 6 stated, he was "up to no good."
-Staff asked resident 6 if she had invited him into her room and she said no.
*On 6/1/24 a CNA reported that after supper he had taken his hand and rubbed resident 7's outer leg, the CNA had intervened, he had stopped and returned to his room.
*On 6/10/24 a housekeeper had notified administrator A that resident 4 had approached resident 1, while she was sleeping, had touched her leg, and staff had intervened.
*On 6/11/24 administrator A had talked to resident 4's son regarding other interventions for his inappropriate touching of female residents.

14. Review of residents 1, 2, 5, 6, 7, and 8's

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eMAR revealed the following BIMS scores:
*Resident 1's 3/27/24 score was a 2, which indicated she had severe cognitive impairment.
*Resident 2's 3/30/24 score was a 99 which indicated she was not able to complete the BIMS questioning process, the staff interview that was then completed indicated she had severe cognitive impairement and was never or rarely understood.
*Resident 6's 4/29/24 score was a 5, which indicated she had severe cognitive impairment.
*Resident 7's 6/5/24 score was a 3, which indicated she had severe cognitive impairment.
*Resident 5's 3/12/24 score was a 2, which indicated she had severe cognitive impairment
*Resident 8's 4/2/24 score was a 9, which indicated she had moderate cognitive impairment.

15. Interview on 6/12/24 at 3:05 p.m. with regional administrator D revealed:
*Administrator A had notified him on 6/12/24 of the incident regarding residents 4 and 8.
*He stated, "This is black and white and should have been taken care of before now."

16. Review of the provider's June 2021 Abuse and Neglect Policy and Procedure revealed:
*To ensure that the center has in place and effective system that regardless of the source prevents mistreatment, neglect and abuse of residents of misappropriation of their property."
*"To ensure that resident are not subject to abuse by anyone, including, not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals."
*"To ensure that all identified incidents of alleged

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{F 600}	Continued From page 9 or suspected abuse/neglect are promptly investigated and reported." *"All staff are responsible for reporting any situation that is considered abuse, neglect, or injury of unknown origin, misappropriation of resident property or involuntary seclusion." *"The charge nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required, and complete an initial investigation. If this is an injury of unknown origin, the charge nurse will also attempt to determine the cause of the injury. The charge nurse will also ensure that any potential for further abuse is eliminated by taking on of the following actions: -"If it is resident to resident abuse, the abused resident will be removed to a safe environment." *"Notification Procedure:" -"Notify the center administrator immediately of any incident of resident abuse." -"Notify the designated agencies in accordance with state law, including the state survey and certification agency." -"If the agencies require an online report to be submitted contact the Social Services Designee, DON, and Administrator." -"Notify the physician and family regarding the facts of the situation. If there is alleged or suspected abuse/neglect or an injury of unknown origin, inform them that an investigation is in process."	{F 600}		