

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/05/2015
NAME OF PROVIDER OR SUPPLIER CENTERVILLE CARE AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 VERMILLION ST CENTERVILLE, SD 57014		
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F 000	INITIAL COMMENTS Surveyor: 33488 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/3/15 through 8/5/15. Centerville Care and Rehab Center was found not in compliance with the following requirements: F226, F250, F252, F325, F371, F431, and F441.	F 000	<i>Addendums noted with an asterisk per 9/15/15 email from facility administrator. NPA/SD00H/JJ</i> The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, confidential resident interview, interview, and policy review, the provider failed to ensure a single concern voiced by two residents about staff neglecting their care responsibilities was thoroughly investigated and documented per facility policy. Findings include: 1. Interview on 8/4/15 at 11:00 a.m. with a confidential resident revealed: *There was another resident who had complained to him she had her call light on for an extended period of time. *She had to go to the bathroom and could not hold it any longer and ended up having a toileting accident in bed.	F 226 F226	Residents' information remained confidential, unable to investigate abuse/neglect concerns. All other residents' abuse/neglect concerns were reviewed to ensure that a proper investigation was completed and documented. Administrator, Social Services designee, and interdisciplinary team reviewed and revised as necessary the policy and procedures about abuse/neglect concerns and investigation process. <i>* See page 2 NPA/SD00H/JJ</i> <i>* or designee NPA/SD00H/JJ</i> Social Services designee will audit all new abuse/neglect concerns one time per week for four weeks and monthly for two more months to ensure proper investigation was completed and documented.	9/24/15	

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

TITLE

(X6) DATE

[Signature]

Emergency Permit Holder

8/27/2015

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.

AUG 31 2015
SD DOW LSC

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

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F 226	<p>Continued From page 1</p> <p>Interview on 8/4/15 at 3:30 p.m. with the resident who was addressed in the previous conversation revealed the above situation had occurred. She felt sad about that and stated "It made me cry. The nurse said I was a naughty girl."</p> <p>Interview on 8/5/15 at 10:50 a.m. with the social services designee regarding the incident with the above resident revealed: *She had been made aware of resident concerns regarding cares provided by staff through the course of time. -That resident was confused at times and had a history of incontinence. *She had only recently been made aware the above resident had that toileting incident event occur. *There had been two staff whose names came up every once in awhile regarding concerns with their care of residents. *She always informed the director of nurses (DON) of any concerns or accusations she had received regarding resident care. -She was not informed of the follow-up that had occurred for the resident.</p> <p>Interview and review of two unidentified employees' counseling forms on 8/5/15 at 11:20 a.m. with the administrator and director of nurses revealed: * ___[name of employee] received a 'written reprimand' on 6/25/15 regarding: -Work not getting completed. -Being disrespectful to staff and residents: Example ___[name of resident with dementia] (confusion). -Unprofessional language used in resident rooms. * ___[name of employee] received a 'written</p>	F 226	<p>Social Services or designee will present findings from these audits at the monthly QAPI meetings for review.</p> <p><i>* Education prepared by Social Services consultant presented by Administrator to all staff on how to appropriately investigate and document concerns identified.</i> <i>NPN/SOONH/JS</i></p>	
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F 226	<p>Continued From page 2 reprimand' regarding: -Lack of compassion to residents during end of life care. -Delegating job responsibilities to others. *That was the only documentation regarding the concerns brought to their attention about those staff. *There was not a record of who had been interviewed as part of the review/investigation. *They confirmed there was not a record of: -What work was not getting completed, such as toileting a resident, failing to provide proper care to a resident? Was it neglect? -What was done to the resident that was disrespectful? Was the resident(s) interviewed? Who was involved? -What language was used? Were they swearing or speaking in a threatening way? -Did they verify the nurse had not delegated responsibilities to other caregivers that were out of their scope of practice? Who was interviewed? Were residents interviewed? *They further confirmed: -The administrator had not been informed of the second reprimand. -They had not used the investigative document required by state law according to their policy. -The counseling form was the only documentation they had.</p> <p>Review of the provider's 2007 abuse policy revealed: **The administrator or other facility staff, including Social Services shall initiate an investigation of alleged violations within 24 hours. *The investigative team shall document all discussions, observations, findings, and conclusions on a facility incident report. *The administrator or designated staff shall report</p>	F 226			

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F 226	Continued From page 3 the results of all investigations to other officials in accordance with State law (including to the State survey and certification agency) within five working days of the incident. *The investigative team shall generate a written summary based on all discussions, observations, documentation (incident reports, departmental notes, etc) findings, and conclusions of their investigation of each alleged violation. *Contents of the report shall include: -Name of resident and staff or volunteers. -What allegedly occurred. -Witnesses. -Who was interviewed. -Content of interview. -Resident reaction. -Circumstances surrounding the incident."	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (3) who exhibited uncooperative behaviors with care had a behavior management plan. Findings include: 1. Review of resident 3's progress notes revealed on the following dates:	F 250	F250 Resident 3's uncooperative behaviors with cares were reviewed to ensure a behavior management plan was implemented. All other residents with a history of uncooperative behaviors with cares were investigated to determine that a behavior management plan was implemented* and no residents required a plan to be implemented. NPN/SDDH/JJ Administrator, DON, and interdisciplinary team reviewed and revised as necessary the policy and procedures about behavior management. * see page 5 NPN/SDDH/JJ	9/24/15

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F 250	<p>Continued From page 4</p> <p>*2/19/15, "He refuses to help himself and times refuses to work with therapies. He talks about returning home. He is told when he works hard and shows improvement that possibility is there for him."</p> <p>*3/24/15, "He can do many things on his own just chooses not to."</p> <p>*5/12/15, "Resident continues to exhibit behaviors r/t [related to] his cares. He refuses to toilet in timely manner or toilet when staff ask him to. He feels that changing him is staff's job. Pain medicating has been attempted to be backed off but he has huge behaviors because he feels he needs it throughout day."</p> <p>*5/14/15, "Resident refused his sliding scale insulin (a medication for the treatment of diabetes) at HS [bedtime]."</p> <p>*5/28/15, "Res [resident] refused his sliding scale insulin at HS."</p> <p>*6/10/15, "_____[name of resident] is always visiting with the ladies holding or rubbing their hands. Most of the ladies have some dementia (confusion) and he is telling them how much he loves them."</p> <p>*6/14/15, "Refused blood sugar and refused to take early morning medication."</p> <p>*6/18/15, "Resident's chair saturated with urine. He refuses to allow staff to toilet him on a regular basis and especially at night. He will lay in soaked clothing because he does not want to get up. This has been an ongoing issue with staff."</p> <p>*6/30/15, "Resident became very upset over incident where staff intervened preventing another resident from driving this resident somewhere. Was shaking his fist and fingers. Could not talk in a normal voice because he was so upset. Staff said he has been very delusional (confused) at times and making comments that lead them to believe he could possible hurt them."</p>	F 250	<p>DON or designee will audit all residents with new uncooperative behaviors with care to ensure a behavior management plan has been implemented one time per week for four weeks and monthly for two more months.</p> <p>DON or designee will present findings from these audits at the monthly QAPI meetings for review.</p> <p><i>* Education prepared by Social Services Consultant presented by Administrator to nursing staff on uncooperative behaviors with cares and enduring a behavior management plan if implemented.</i> <i>NPN/SD004 JJ</i></p>	
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F 250	<p>Continued From page 5</p> <p>Department of Social Services and the Ombudsman (advocate) will be notified."</p> <p>*7/1/15, "Refused to take medication for agitation."</p> <p>*7/2/15, A family "expressed concerns regarding this resident making them uncomfortable related to delusions. The husband feels that he is preying on residents with cognition issues [confused] and that his wife is very confused by what is happening."</p> <p>*7/3/15, "Resident refused the ordered 6 units (of insulin) wanted me to give only 3 units."</p> <p>*7/8/15, "Resident's physician was notified with guidance related to his behaviors towards staff, and residents. He was refusing cares and problems related to women in the facility [there was nothing specific documented]." On that date:</p> <ul style="list-style-type: none"> -The physician made a recommendation to have a mental health evaluation. -The resident was sent for an evaluation." There was no further documentation on that. <p>*7/9/15, Refused the sliding scale insulin.</p> <p>*7/15/15, "Continues to talk with at risk people with dementia or like issues. One family member was in to complain about him bugging his wife so much that she is beginning to feel threatened by him. Other concerns have come in from other family members that he is being very obtrusive (interfering) and trying to push his beliefs onto them. They are feeling quite uncomfortable with the situation and one resident states she has tried to talk him out of his delusions and or distract him from his 'mission'."</p> <p>*From 7/15/15 through 8/3/15 he refused his sliding scale insulin, refused to tell the nurse how much pain he had when he asked for a pain medication, and refused to follow through with a referral for a mental health evaluation.</p> <p>*There was no documentation that staff had:</p>	F 250		

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F 250	<p>Continued From page 6</p> <p>-Assessed why he refused his sliding scale insulin or addressed that with the physician. -Tried to establish a plan in light of the family concerns regarding his behavior to protect the other residents. -Assisted him in accessing the things in the community, so he would not ask his peer to drive him around town. -Assessed his refusal to tell staff about whatever pain he was having.</p> <p>Interview on 8/5/15 at 11:00 a.m. with the social services designee/licensed practical nurse regarding resident 3 revealed: *He had been a very difficult resident to work with. *He visited at length with some of the residents and has been upsetting to them. *Physically he did quite well now with his own care, it was his behaviors that presented the most challenges. *He had refused to have a mental health evaluation.</p> <p>Review of resident 3's 2/12/15 care plan revealed: *Focus: Is very pleasant and alert. Is very social with everyone. -It had nothing regarding the behaviors that had been addressed by other residents and family members. *Focus: Has chronic pain related to depression, diabetic peripheral neuropathy (nerve damage caused by chronically high blood sugars), and lower back pain. -It had not addressed his refusals to be assessed for pain, and how they had addressed that behaviorally. *Focus: Bladder incontinence.</p>	F 250			

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F 250	<p>Continued From page 7</p> <p>-It had not addressed his refusal to accept help with that, and how they had addressed that behaviorally. *The care plan had not addressed his behaviors in general.</p> <p>Review of the provider's 2007 Refuse Treatment/Social Services policy revealed: *"When/if a resident refuses to participate in a treatment as indicated in his/her care plan, or as recommended by the physician or other health care professional social service and nursing staff will: -1. Assess the reason for the resident's refusal -2. Explain the consequences of the refusal to the resident. -3. Offer alternatives. -4. Document the conversation and the outcome in the Social Service and Nursing Progress Notes. -5. When/if the refusal results in a significant change in the resident, the facility should reassess the resident and initiate changes in the care plan."</p> <p>Review of the provider's February 2005 behavioral causes and interventions policy revealed: *The purpose was to "aid in determining causes of behavior and appropriate intervention and strategies." *"Be a detective! Try to determine what is causing the behavior? Is the behavior related to the residents: -Physical or emotional health? -Environment? -Communication? -Ability to perform tasks? -Caregiver's approach?"</p>	F 250			

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F 252 SS=E	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, and preventative plan review, the provider failed to ensure: *Four of four resident wings (Side 1, Side 2, Side 3, and Side 4) had door frames and doors that were in good condition and had cleanable surfaces. *One of one therapy room and one of one beauty shop had equipment that was in good condition and were clean. *Items were stored properly in one of one supply room. Findings include:</p> <p>1. Random observations from 8/3/15 through 8/5/15 on all four resident wings (Side 1, Side 2, Side 3, and Side 4) revealed: *Resident door frames had large amounts of chipped paint. *Doors into resident rooms had numerous areas of chips in the wood and left an uncleanable surface and the potential for splinters. *Double-doors (fire doors) had numerous areas of chipped wood leaving an unclean surface and the potential for splinters.</p> <p>2. Observation on 8/3/15 at 4:30 p.m. in the therapy room revealed:</p>	F 252	<p>F252</p> <p>The facility was reviewed to ensure all door frames, doors, and equipment have cleanable surfaces in hallways, therapy room, and beauty shop and items are stored properly in nursing supply room.</p> <p>Administrator and Environmental Services Manager reviewed and revised as necessary the policy and procedures about preventative maintenance relating to cleanable surfaces. <i>* See page 10 NPN/SDOH/JJ</i> Environmental Services Manager or designee will audit the facility to ensure all door frames, doors, and equipment have cleanable surfaces and items are stored properly in nursing supply room one time per week for four weeks and monthly for two more months.</p> <p>Environmental Services Manager will present findings from these audits at the monthly QAPI meetings for review.</p> <p><i>* Environmental Services Manager will provide education to all staff on how and when to report non-cleanable surfaces needing to be addressed to the maintenance department. NPN/SDOH/JJ</i></p>	9/24/15
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F 252	<p>Continued From page 9</p> <ul style="list-style-type: none"> *The platform for feet on the Nu-step had dirt and debris built up in the corners. *The exercise mat had large tears in the edges leaving an uncleanable surface and the potential for skin tears. *The balance pad was covered with cracks leaving an uncleanable surface. *There were wood chips on the steps residents practiced walking up and down leaving an uncleanable survey and the potential for splinters. *A ceiling light fixture had about a twelve inch crack in it. *The wall behind the sink had exposed dry wall leaving an uncleanable surface. <p>3. Observation on 8/3/15 at 4:35 p.m. revealed a vinyl covered booster seat in the beauty shop that had many cracks and tears on it, creating an uncleanable surface.</p> <p>4. Observation on 8/3/15 at 4:45 p.m. and on 8/5/15 at 10:15 a.m. with the administrator and environmental services supervisor (ESS) revealed: *Packaged catheter supplies were being stored in a bin in a functional sink. *Personal care items including urine hats, spittoons, and wash basins were stored under the sink.</p> <p>5. Interview on 8/5/15 at 10:00 a.m. with the ESS revealed: *They were aware the door frames were chipped, and doors had exposed wood. -It was an ongoing problem they were always trying to address. -This was not on their preventative maintenance program. It was more something they just touched up when they saw it.</p>	F 252	<p><i>*Preventative maintenance program created to ensure all door frames, doors, and equipment have cleanable surfaces.</i></p> <p><i>NPAL5AD0H/JJ</i></p>		

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F 252	Continued From page 10 *She confirmed the areas of uncleanable surfaces in the therapy room and beauty shop. Review of the provider's preventative maintenance plan revealed: *It had not addressed maintaining doors and door frames in good condition. *On a weekly basis they were to check all lights in the facility. *On a monthly basis they were to inspect wheelchairs or other assistive devices. -It had not specifically addressed exercise mats or booster seats.	F 252		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure nutritional parameters for controlling his diabetes and weight were met for one of one sampled resident (3) with diabetes. Findings include:	F 325	F325 Resident 3's nutrition status for controlling diabetes and weight was reviewed to ensure nutritional parameters were in place. All other residents with diabetes were reviewed to ensure nutritional parameters were in place. <i>* see Page 12 NPN/5000H/JJ</i> Dietary Manager or designee will audit all residents with new complications controlling diabetes and weight one time per week for four weeks and monthly for two more months. Dietary Manager will present findings from these audits at the monthly QAPI meetings for review.	9/24/15

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F 325	<p>Continued From page 11</p> <p>1. Review of resident 3's 7/1/15 physician's order revealed he was on a modified diabetic diet.</p> <p>Review of resident 3's weight record revealed on 1/26/15 at admission he weighed 142.6 pounds (lb). His weight on 8/3/15 was 170 lb.</p> <p>Review of resident 3's nurses progress notes revealed: *5/14/15, "Resident refused his sliding scale insulin (a medication for the treatment of diabetes) at HS [bedtime]." *5/28/15, "Res [resident] refused his sliding scale insulin at HS." *6/14/15, "Refused blood sugar and refused to take early morning medication." *7/9/15, "Refused the sliding scale insulin." *From 7/15/15 through 8/3/15 he refused his sliding scale insulin repeatedly with concerns his blood sugars would get too low.</p> <p>Random review of resident 3's Medication Administration Records which contained a record of his blood sugar monitoring revealed in May and July of 2015 his blood sugars ranged from 98 to 426. His usual range was 150 to 300.</p> <p>Review of resident 3's progress notes revealed the dietary manager had received the following warnings: *5/5/15, Weight warning related to a 5 percent (%) increase in his weight. *6/11/15, Weight warning related to a 7.5% increase in his weight. *6/22/15, Weight warning related to a 7.5% increase in his weight. *6/30/15, Weight warning related to a 10% increase in his weight. *7/31/15, Weight warning-current weight 171 lb.</p>	F 325	<p>* Education to Dietary Manager on intervention and documentation about residents with diabetes and nutritional parameters by dietician. NPN/SDP00H/JJ</p> <p>* Administrator and Dietary Manager reviewed and revised as necessary the policy and procedures about diabetes and nutritional parameters. NPN/SDP00H/JJ</p>	

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F 325	<p>Continued From page 12</p> <p>Interview on 8/4/15 at 4:00 p.m. with the director of nurses and the social services designee regarding resident 2 revealed: *His physician had not sent progress notes despite their repeated requests. *They only recently became aware his physician was a physician assistant (PA). -When they became aware of that they had him seen by their medical director. -That report was in his chart. *During this survey they called the resident's regular PA and requested the progress notes that were promptly sent to the facility. *Further interview revealed they did not get laboratory test results (labs) sent to them, so they were unaware if any pertinent lab work related to his diabetes had been completed.</p> <p>Review of resident 3's 2/12/15 care plan revealed: *Focus: Resident has a potential nutritional problem related to diabetes type II (adult onset). -Took insulin (for blood sugar control). -Admit weight 143 lb. *Approaches included: -Independent in dining. -Serve diet as ordered. -Weigh weekly. *On 5/15/15 they addressed the 10% weight gain. -The goal was for stable weight, but there were no interventions to address that.</p> <p>Review of resident 3's nutrition notes revealed the registered dietitian (RD) had not reviewed his weights or documented on him since 2/12/15. She had not addressed his unstable blood sugars, his refusal of his insulin, or his weight gain.</p>	F 325		
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F 325	<p>Continued From page 13</p> <p>Interview on 8/5/15 at 8:00 a.m. with the dietary manager regarding resident 3 revealed: *She confirmed he was on a diabetic diet. *He basically ate what he wanted, but they had tried to watch carbohydrates on that diet. *Their electronic medical record (EMR) only had so many options when his diet was input and 'diabetic diet' was not an option. -The EMR only acknowledged a modified diabetic diet. -It was confusing. -Their menus had not addressed a modified diabetic diet. *When she had identified a nutritional concern with a resident she notified the RD. *She was unaware of his unstable blood sugars, and that he refused his insulin at times. *She was aware of his weight gain. *The RD had not received a referral on him. *She agreed that with his weight loss and his blood sugars the RD should have reviewed him more frequently. *They did not have a nutrition at risk meeting, but reviewed nutritional issues at their quality assurance meeting.</p> <p>Review of the provider's May 2013 Residents with Impaired Nutrition and Nutritional Risk policy revealed: **The center will ensure that each resident maintains acceptable parameters of nutritional status such as body weight, protein levels, and hydration status unless the resident's clinical condition demonstrates that this is not possible. *The director of dietary services (DDS)/registered dietitian (RD) will identify residents with impaired nutrition or at nutritional risk such as: -Insidious weight loss/gain (gradual unintended).</p>	F 325		
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F 325	<p>Continued From page 14</p> <p>*The DDS or designee will review resident weights monthly to identify residents with significant weight loss/gain (5 percent in 30 days, 7.5 percent in 90 days or 10 per cent in 180 days).</p> <p>*The DDS will have a list of residents with impaired nutrition or at nutrition risk. These residents will be addressed at the next nutrition at risk meeting.</p> <p>*The RD will complete the Nutrition Assessment for each resident newly identified with impaired nutrition or at nutritional risk.</p> <p>*On a monthly basis the RD will review the care plan of all residents on the nutrition risk list. This note will include progress or lack of progress towards the goal and any change in intervention."</p>	F 325		
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18560</p>	F 371	<p>F371</p> <p>The kitchen was observed to ensure cleanable surfaces have been maintained, deep cleaning has been done, and food approved hand sanitizers are being used.</p> <p>Dietary Manager and RD reviewed and revised as necessary the policy and procedure about appropriate kitchen cleaning schedule and the use of food approved hand sanitizers. Education will be provided for all staff responsible for cleaning the kitchen and the use of hand sanitizer by September 2, 2015.</p>	9/24/15

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F 371	<p>Continued From page 15</p> <p>Based on observation, interview, and cleaning schedule review, the provider failed to ensure:</p> <ul style="list-style-type: none"> *Cleanable surfaces had been maintained in one of one kitchen. *Food approved hand sanitizers had been used in one of one kitchen. <p>Findings include:</p> <p>1. Observation on 8/3/15 at 1:30 p.m. in the kitchen revealed:</p> <ul style="list-style-type: none"> *The wall immediately to the east of the serving window had an approximately one inch by one inch open area of exposed plaster board. There were several smaller areas. The paint had chipped away making the area an uncleanable surface. *Bottles of instant hand sanitizer with aloe, dial spring water hand soap with moisturizer, and personal care cherry blossom soothing hand soap. <p>Interview on 8/5/15 at 10:20 a.m. with the certified dietary manager (CDM) revealed:</p> <ul style="list-style-type: none"> *The area next to the serving window was where a lot of grilling was done like eggs for breakfast. *There was no set schedule for when to clean the walls. *A deep cleaning of the kitchen had not been done for some time. *There was no plan currently to repair the wall. *She was not aware a food approved hand sanitizer needed to be used. <p>Review of the provider's undated Sanitation Cleaning Schedules revealed it would be the responsibility of the CDM to provide and post daily, weekly, and monthly cleaning schedules in the dietary area. The cleaning schedule had been only for daily and weekly cleaning. No schedule</p>	F 371	<p>Dietary Manager or designee will audit the kitchen one time per week for four weeks and monthly for two more months to ensure the cleaning schedule is being followed, cleanable surfaces are being maintained, and staff are using food approved hand sanitizers.</p> <p>Dietary Manager or designee will present findings from these audits at the monthly QAPI meetings for review.</p>	
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F 371 F 431 SS=D	<p>Continued From page 16 for cleaning of walls had been noted.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 371 F 431	<p>F431</p> <p>All insulin bottles were reviewed to ensure appropriate labeling have been completed.</p> <p>DON or designee will provide education to all nursing staff on the proper way to dispose of Fentanyl patches, the importance of securing medications on medication cart during medication passes, and how to appropriately label insulin bottles.</p> <p>DON or designee will audit the disposal of Fentanyl patches, securing the medication cart, and the labeling of insulin bottles once per week for four weeks and monthly for two more months.</p> <p>DON or designee will present findings from these audits at the monthly QAPI meetings for review.</p> <p><i>* Administrator and DON reviewed and revised the policy and procedures about proper labeling and dating medication in the medication Cart.</i></p> <p><i>NPN/SDM/HJT</i></p>	9/24/15
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F 431	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488</p> <p>Based on observation, interview, manufacturer's guideline review, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> *Ensure all Fentanyl (a controlled narcotic medication) patches were destroyed appropriately after use. *Ensure one of one medication cart and five of five medication containers during one of five observed medication administrations by staff were kept secured. *Ensure all insulin bottles were appropriately labeled with opened and use by dates. <p>Findings include:</p> <p>1. Observation and interview on 8/5/15 at 9:00 a.m. with the infection control nurse regarding the medication cart review revealed: *Fentanyl patches were put on a piece of paper and shredded. They were not secured from possible diversion (taking for personal use). *She had been unaware of manufacturer's guidelines recommending flushing used patches down a drain.</p> <p>Interview on 8/5/15 at 11:00 a.m. with the director of nursing, the administrator and the infection control nurse revealed, they agreed manufacturer's guidelines should have been followed with regard to disposal.</p> <p>Review of the manufacturer's guidelines for Fentanyl pain patch destruction revealed patches should be flushed in the toilet as the preferred method of destruction after use.</p> <p>2. Observation and interview on 8/3/15 at 5:28</p>	F 431			

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F 431	<p>Continued From page 18</p> <p>p.m. with medication aide E administering medications to residents revealed:</p> <p>*She left medication containers unsecured on top of the medication cart while she administered medications to two residents.</p> <p>*The medication cart was left unsecured when she had left her cart to deliver the medications for administration to residents.</p> <p>*She had been employed at the facility for forty eight years.</p> <p>Interview on 8/5/15 at 11:00 a.m. with the director of nursing, the administrator and the infection control nurse revealed they agreed not securing medications or the car during medication pass was an area of concern.</p> <p>Review of the provider's May 2011 Acquisition, Receiving, and Dispensing of Medications policy revealed medications were to be stored in a locked medication room or cart.</p> <p>3. Observation on 8/3/15 at 5:00 p.m. of the infection control nurse accessing insulin from the medication cart revealed:</p> <p>*None of the insulins located in the treatment cart had been dated appropriately labeled with opened and used by dates on the vials.</p> <p>*There had been a date written on the bottles, but it was unclear by the labeling whether it was an opened or a use by date.</p> <p>Interview on 8/5/15 at 9:00 a.m. with the infection control nurse and social services designee regarding insulin dating revealed:</p> <p>*Nursing staff had not appropriately dated any insulin bottles.</p> <p>*The social services designee (who was a licensed practical nurse) would place a reminder</p>	F 431		

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F 431	<p>Continued From page 19 in the electronic medication administration record to alert nursing staff when insulin medications were to no longer be used as recommended by the manufacturer. *That practice began after last year's survey. *The infection control nurse had not been aware of the appropriate dating of insulin.</p> <p>Interview on 8/5/15 at 11:00 a.m. with the director of nursing, the administrator and the infection control nurse, revealed they agreed manufacturer's guidelines needed to be followed along with the institute for safe medication practices guidelines to ensure patient safety when administering insulin from a multi-dose vial by appropriately labeling insulin with "opened ____ and use by ____" labeling.</p> <p>Review of the Institute for Safe Medication Practices, https://www.ismp.org/newsletters/acutecare/show_article.aspx?id=42, accessed on 8/10/15 revealed insulins not dated appropriately could lead to insulins being used that were no longer safe or effective.</p>	F 431		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections</p>	F 441	<p>F441</p> <p>Resident 2's room was observed to ensure cleanable surfaces.</p> <p>All other resident rooms were reviewed to ensure cleanable surfaces.</p>	9/24/15

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F 441	<p>Continued From page 20 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility 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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to: *Use their infection control surveillance data to perform a thorough investigation for infection causes and preventative measures for one of one infectious disease process related to Clostridium difficile (C-diff)(a highly contagious and harmful bacteria spread through contact with with bowel movement).</p>	F 441	<p><i>* See Page 22 NP/5000H/JJ</i></p> <p>Administrator and Environmental Services Manager reviewed and revised as necessary the policy and procedures about preventative maintenance to ensure cleanable surfaces in resident rooms and appropriate cleaning of resident rooms with identified infection.</p> <p>Environmental Services Manager or designee will audit all residents' rooms to ensure cleanable surfaces are maintained one time per week for four weeks and monthly for two more months. → <i>and appropriate cleaning of resident rooms with identified infection</i> Environmental Services Manager or designee will present findings from these audits at the monthly QAPI meetings for review. <i>* See Page 23 NP/5000H/JJ</i></p> <p>Education will be provided for all staff responsible for the cleaning of resident rooms, equipment, and whirlpool tub to ensure guidelines of infection control are being followed September 2, 2015. <i>* See Page 22 NP/5000H/JJ</i></p> <p>Education will be provided for all staff responsible for personal catheter care to ensure guidelines of infection control are being followed.</p>		

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F 441	<p>Continued From page 21</p> <ul style="list-style-type: none"> * Ensure appropriate cleaning had been performed in one of one resident's (2) room with C-diff. * Ensure staff used the appropriate personal protective equipment (PPE) while cleaning one of one resident (2) room with a C-diff infection. * Ensure surfaces in one of one resident room (2) were found to be a cleanable surface. * Ensure one of one glucometer (used to check a resident's blood sugar) had been cleaned appropriately between resident use. * Ensure one of one whirlpool tub had been cleaned appropriately and PPE was used during cleaning by staff between resident use. * Ensure personal care was performed to maintain infection control practices on one of one observed resident's (5) personal care. <p>Findings include:</p> <p>1. Interview on 8/5/15 at 10:15 a.m. with the infection control nurse regarding her monthly surveillance of infections within the facility revealed:</p> <ul style="list-style-type: none"> * Resident 2 had been admitted to the facility in April 2015. In May she developed a C-diff infection and had been placed on isolation and antibiotic therapy. * She would track and trend infections and place that information in a folder for the director of nursing (DON) to take to the monthly infection control/quality meetings. * She used to attend the meetings but no longer attended. * She would implement any changes or follow-up deemed necessary brought forth from the above meeting. <p>Review of the monthly quality assurance meeting minutes held in July 2015 revealed:</p>	F 441	<p>Administrator, DON, infection control nurse, and interdisciplinary team to review and revise, create as necessary policies and procedures about appropriate use of infection surveillance data, appropriate education for all facility staff about the use of personal protective equipment (PPE) and isolation procedures, appropriate cleaning and maintenance of glucose monitors, and appropriate cleaning and sanitation of whirlpool tub including when used by someone with identified infection.</p> <p><i>* Resident 2's room was reviewed to ensure appropriate cleaning is done, staff use appropriate PPE while cleaning resident's room, and ensure surfaces are a cleanable surface. NPN/SDC/H/JT</i></p> <p><i>* Education will be provided for all staff responsible for cleaning glucometer after use with a resident with C-diff. NPN/SDC/H/JT</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2015	
NAME OF PROVIDER OR SUPPLIER CENTERVILLE CARE AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 22</p> <p>*The C-diff infection information was brought to the attention of the medical director who recommended further isolation for resident 2.</p> <p>*There was no investigation by an interdisciplinary committee regarding the data brought to the meeting or the root cause (reason why) of her recurrent infection.</p> <p>2. Interviews on 8/4/15 with housekeepers D and F from 9:45 through 10:00 p.m. regarding the environmental cleaning of a room for resident (2) with C-diff revealed neither housekeeper: *Was aware the recommended cleaning solution for C-diff was a bleach solution. *Had not used a bleach solution to clean the floor in the above resident's room. *Were unsure exactly what PPE they (housekeeping staff) would need to put on before cleaning the resident's room.</p> <p>3. Interviews on 8/4/15 with housekeepers D and F from 9:45 through 10:00 p.m. regarding the environmental cleaning of a room for resident (2) with C-diff revealed: *Neither housekeeper was aware the two dressers with chipped surfaces found in resident 2's room were considered uncleanable and could potentially promote bacteria to remain on the surface. *The mop itself had not been designated to the resident's room and would be wiped down with a bleach containing wipe. *Both housekeepers would not change gloves after cleaning the room or before sanitizing the mop handle prior to removing it from the room.</p> <p>Interview on 8/5/15 at 10:20 a.m. with the maintenance supervisor on at regarding the cleaning of resident 2's room and the chipped</p>	F 441	<p>* Education will be provided to housekeeping to ensure appropriate cleaning to resident rooms with C-diff. NPN/SP004/JJ</p> <p>* Education to all staff to ensure C-diff precautions are followed. NPN/SP004/JJ</p> <p>* Resident 5's personal catheter care was reviewed to ensure infection control practices are maintained. NPN/SP004/JJ</p> <p>* DON or designee will audit all residents with urinary catheter cares to ensure infection control practices are maintained one time per week for four weeks and monthly for two more months. NPN/SP004/JJ</p> <p>* DON or designee will present findings from these audits at the monthly QAPI meetings for review. NPN/SP004/JJ</p>	

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F 441	<p>Continued From page 23</p> <p>surfaces on furniture revealed: *She was unsure of the guidance for PPE gear as it related to her staff. *Was not aware the chipped furniture could promote the C-diff bacteria to live in the surfaces of the uncleanable wood. *She had no preventative maintenance plan for chipped surfaces resident 2's room or throughout the facility.</p> <p>4. Observation on 8/3/15 with the infection control nurse as she performed glucometer checks prior to administering insulin to residents revealed: *After her glucometer check, she would use a disposable quaternary wipe product (Sani-Cloth) to clean the multi-use glucometer. *She had not allowed the surface to remain wet between resident use for the recommended two minutes needed to sanitize the glucometer. *That glucometer had also been used on the resident who had C-diff. *It had not been cleaned with an appropriate bleach wipe. *She was unaware the Sanicloths would not kill the C-diff bacteria. *The glucometer was used on all residents who required insulin.</p> <p>5. Observation on 8/4/15 at 9:10 a.m. of the whirlpool cleaning performed by certified nursing assistant (CNA) B revealed: *She had not worn gloves when touching surfaces inside the whirlpool. *Was unaware the whirlpool quaternary sanitizer was not effective against C-diff.</p> <p>Interview on 8/4/15 at 11:30 a.m. with CNA C regarding the whirlpool cleaning revealed: *She also had used the whirlpool cleaner to</p>	F 441			

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F 441	<p>Continued From page 24</p> <p>sanitize the whirlpool between resident use and had not used a bleach solution after resident 2 had used the whirlpool. *Resident 2 would take her bath Fridays but at different times. Some residents had been bathed after her on occasion.</p> <p>6. Observation and interview on 8/5/15 at 9:10 a.m. with CNA A performing personal catheter care on resident 5 revealed: *She had not placed a barrier down prior to beginning catheter care for the resident. *The resident's buttocks touched her bedspread as a result during the catheter care. *She had not performed hand hygiene in between tasks during the catheter care. *With her soiled gloved hands she touched several surfaces that included her hair, the resident's shirt, and her scrubs (uniform). *She placed a contaminated tube of personal care barrier cream in her scrub top after applying it to the resident while wearing her contaminated gloves. *She agreed she should have: -Changed her gloves between tasks. -Applied a barrier to the resident's clean bedding. -Not placed contaminated personal barrier cream that she had used on the resident into her scrub pocket.</p> <p>Interview on 8/5/15 at 11:00 a.m. with the director of nursing, the administrator, and the infection control nurse revealed they agreed: *The infection control nurse needed to be a part of their infection control/quality meetings. *There was no investigation into the cause or prevention of recurrent C-diff infection. *Personal care provided by CNA A should have maintained infection control practices.</p>	F 441			

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F 441	<p>Continued From page 25</p> <p>*The whirlpool tub was not appropriately cleaned after being used by a resident with C-diff.</p> <p>Review of the provider's undated Surveillance (the process of monitoring from beginning to end of infections including treatment and prevention of future inection) policy revealed: *Process (how it is prevented) surveillance monitored compliance with infection control with practices such as precautions and hand hygiene. *Outcome (the end result) surveillance was designed to identify, report, and analyze the data.</p> <p>Review of the undated Infection Preventionist policy revealed they: *Would serve as the chairperson of the infection control committee. *Provide orientation to all new employees as well as continuing education to all employees. *Notify and communicate with the medical director the information gathered. *Would continually monitor employee infection control practices.</p> <p>Review of the undated Infection Control Committee Policy revealed: *The infection preventionist was recommended to attend the meetings. *The committee would review action taken by staff and recommend corrective action.</p> <p>Review of the undated Mayo Clinic C-difficile guidelines received from the provider revealed thorough cleaning with a bleach product to kill the organism.</p> <p>Review of the provider's November 2006 Resident Rooms- Occupied Isolation policy revealed:</p>	F 441			

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F 441	Continued From page 26 *There was no mention of disinfecting the mop prior to removing it from the resident's room. *Cleaning staff were to wash hands, put on a gown, face mask, and rubber gloves prior to entering the room.	F 441			

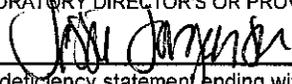
ORIGINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435088	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2015
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/4/15. Centerville Care and Rehab Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 8/4/15 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiency identified at K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	K000	
K 033 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and document review, the</p>	K 033		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Emergency Permit Holder	(X6) DATE 8/27/2015
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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.

AUG 31 2015

SD DOH LSC

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K 033	Continued From page 1 provider failed to ensure there were at least two conforming exits from the basement. Findings include: 1. Observation at 10:00 a.m. on 8/4/15 revealed the basement had only one conforming exit. The east exit discharged into the main level corridor system. A one hour fire resistive path of egress was not maintained to the exterior of the building. Review of previous survey data identified that condition had existed since the original construction. This deficiency would not have any effect on resident safety.	K 033		
K 069 SS=D	The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000. NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on document review and interview, the provider failed to ensure the kitchen hood fire suppression system was connected to the building's fire alarm signaling system for one of one kitchen hood. Findings include: 1. Document review at 11:30 a.m. on 8/4/15 of the commercial kitchen equipment inspection report for the August 2015 inspection identified the kitchen hood fire suppression system was not connected to the building fire alarm system.	K 069	K069 The kitchen hood fire suppression system is scheduled to be connected to the building's fire alarm system by Midwest Alarm Company. Midwest Alarm Company is schedule to give a quote August 28, 2015. Environmental Services Manager or designee will audit kitchen hood fire suppression system once per month for three months to ensure the system is connected to the buildings fire alarm system.	9/24/15

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K 069	Continued From page 2 Interview with the kitchen hood inspector servicing the suppression system confirmed the hood suppression system was never connected to the building fire alarm system. Interview with the director of environmental services at the time of the document review revealed she was unaware of the requirement. This deficiency could affect the safety to staff and residents due to fire and smoke.	K 069	Environmental Services Manager or designee will present findings from these audits at the monthly QAPI meetings for review.	

ORIGINAL

South Dakota Department of Health

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S 000	Initial Comments Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/3/15 through 8/5/15. Centerville Care and Rehab Center was found not in compliance with the following requirement(s): S206.	S 000	S000 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (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; and (10) Dining assistance, nutritional risks, and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs.	S 206	S206 Administrator, DON, and interdisciplinary team to review and revise, create as necessary policies and procedures about ongoing medication aide training and evaluate competencies for medication administration. DON or designee reviewed all aides who administer medications records to ensure ongoing education and competency evaluations. DON or designee will audit all aides who administer medications records once per month for three months to ensure ongoing education and competency evaluation are completed. DON or designee will present findings from these audits at the monthly QAPI meetings for review.	9/24/15

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

Wesley Anderson

TITLE

Emergency Permit Holder

(X6) DATE

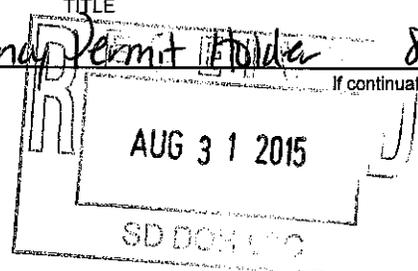
8/27/2015

STATE FORM

6899

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If continuation sheet 1 of 2



South Dakota Department of Health

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S 206	<p>Continued From page 1</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33488 Based on interview the provider failed to have ongoing yearly training for aides who administered medications to all residents. Findings include:</p> <p>1. Interview on 8/4/15 at 11:00 a.m. with the director of nursing regarding medication aides and their training revealed the provider was not aware they needed to: *Provide additional ongoing training for medication aides. *Evaluate competencies for medication administration.</p> <p>There was no policy related to ongoing medication aide training.</p>	S 206		