

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 06/29/2016
NAME OF PROVIDER OR SUPPLIER CENTERVILLE CARE AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 VERMILLION ST CENTERVILLE, SD 57014		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><i>*Addendums noted with an asterisk per 8/10/16 per email with facility administrator. NPN/SPD/DH/EL</i></p> <p>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 6/27/16 through 6/29/16. Centerville Care and Rehab Center was found not in compliance with the following requirements: F281, F323, F441.</p>	F 000	F000 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 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 A. Based on record review and interview, the provider failed to clarify physician's orders regarding psychoactive medications and their associated diagnoses in the electronic medical record (EMR) for four of five sampled residents (1, 6, 8, and 10). Findings include:</p> <p>1. Review of the current active medication administration record (MAR) for resident 1 revealed three medications that were being administered (lorazepam, olanzapine, and trazodone). All had associated diagnoses of anxiety.</p> <p>Review of the 2/24/16 scanned physician recertification documentation revealed: *Olanzapine had an associated diagnosis of mood disorder. *Trazodone had an associated diagnosis of insomnia.</p>	F 281	<p>F 281 *A</p> <p>Resident 10 has been discharged.</p> <p>Resident 1, 6, and 8's medication administration record (MAR) were reviewed to ensure the physicians' orders regarding psychoactive medications and their associated diagnoses in the electronic medical record (EMR) coincide.</p> <p>All other residents that are prescribed psychoactive medication were reviewed to ensure physicians' orders regarding psychoactive medications and their associated diagnoses in the EMR coincide. <i>*and due for their recertification NPN/SPD/DH/EL</i></p> <p>DON, pharmacist, and interdisciplinary team reviewed and revised as necessary the policy and procedure about receipt and clarification of physician orders.</p>	8/18/16	

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

Jessie J. Jaramila

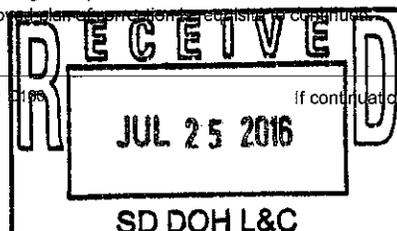
TITLE

administrator

(X6) DATE

7/21/16

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 required for continued program participation.



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F 281	<p>Continued From page 1</p> <p>*Lorazepam was the only medication that was to have been given for anxiety.</p> <p>Surveyor 34030 2. Review of the current active MAR for resident 6 revealed one medication he was receiving, Seroquel, had an associated diagnosis of agitation.</p> <p>Review of a 5/4/16 behavioral health physicians' evaluation and management note stated resident 6 was on Seroquel for dementia with behavioral disturbance.</p> <p>Surveyor 33488 3. Review of the current active MAR for resident 8 revealed: *Mirtazapine was given for depressive type psychosis. *Nuedexta was given for behavior. *Olanzapine was given for depressive type psychosis. *Trazodone was given at bedtime for anxiety. *Venlafaxine was given for depressive type psychosis. *Lorazepam was given for anxiety.</p> <p>Review of the 3/30/16 scanned physician recertification documentation revealed: *The mirtazapine and trazodone were to have been given for insomnia. *The diagnosis for both the olanzapine and venlafaxine was mood disorder. *The lorazepam was given for anxiety.</p> <p>4. Review of the medication administration record (MAR) for resident 10 revealed: *An order for Seroquel 25 milligrams (mg) twice daily for anxiety.</p>	F 281	<p>DON or designee will provide education on how to appropriately ensure physicians' orders regarding psychoactive medications and their associated diagnoses in the EMR coincide to all staff who may be responsible for imputing physician orders on or before July 29, 2016.</p> <p>DON or designee will audit all resident that are prescribed psychoactive medications once a week for four weeks and monthly for two more months to ensure physicians' orders regarding psychoactive medications and their associated diagnoses in the EMR coincide has been completed.</p> <p>DON or designee will present findings from these audits at the monthly QAPI meetings for review.</p> <p><i>*Until audits are completed. NPN/SDDO/H/EL</i></p>	

**and due for their recertification.
NPN/SDDO/H/EL*

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F 281	<p>Continued From page 2</p> <p>*Another 50 mg dose of Seroquel was ordered at night with the diagnosis of "anti-psychotic".</p> <p>Review of the 4/15/16 facility's discharge diagnoses list for resident 10 revealed: *Dementia with behavioral disturbance. *Dementia without behavioral disturbance.</p> <p>Interview on 6/29/16 at 4:15 p.m. with the director of nursing (DON) regarding the above residents' diagnoses and medications revealed: *She agreed the medications diagnoses listed above had not matched their physician's diagnoses listed in the residents' medical records. *The diagnoses listed for each medication was likely one received upon admission from another provider. *They had not updated the information in the EMR. *She agreed all medications should have been verified for accuracy upon admission and as changes occurred. *There was no policy related to updating the EMR on medications and associated diagnoses. Surveyor: 34030</p> <p>B. Based on observation, interview, and procedure review, the provider failed to assess for effectiveness one of one randomly observed resident (11) with a nebulizer treatment. Findings include:</p> <p>1. Observation and interview on 6/28/16 at 11:00 a.m. of registered nurse (RN) H giving resident 11 a nebulizer treatment revealed: *She was the only nurse giving nebulizer treatments and would give several of them during the course of the day. *She placed the medication into the nebulizer chamber and administered it to the resident.</p>	F 281	<p>F281 *B</p> <p>Resident 11's nebulizer treatments were reviewed to ensure resident's treatments were appropriately assessed.</p> <p>All other residents with nebulizer treatments were reviewed to ensure residents' treatments were appropriately assessed.</p> <p>DON and interdisciplinary team reviewed and revised as necessary the policy and procedure about appropriate assessment when administering a nebulizer treatment.</p> <p>DON or designee will provide education on how to appropriately assess residents when administering a nebulizer treatment on or before July 29, 2016. *to all staff who may be responsible for administering a DON or designee will audit all nebulizer treatments once a week for four weeks and monthly for two more months to ensure residents' treatments were appropriately assessed.</p> <p>DON or designee will present findings from these audits at the monthly QAPI meetings for review *until audits are completed.</p>	8/18/16
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F 281	<p>Continued From page 3</p> <p>*No assessment had been done to check the resident's: -Breath sounds before or after the treatment. -Level of oxygen. -Pulse rate.</p> <p>*When asked how she knew whether the treatment had been effective or not RN H stated: -"We checked her O2 sat (oxygen saturation) this morning." -"I can tell by the resident's wheezing."</p> <p>Interview on 6/28/16 at 4:45 p.m. with licensed practical nurse F regarding administration of nebulizer treatments revealed she: *Also gave them but was not working in that capacity today. *Would check an oximeter reading after the treatment. *Did not check resident's breath sounds or a pulse before or after a nebulizer treatment. *Agreed they probably should have assessed the resident's breath sounds and pulse.</p> <p>Interview on 6/29/16 at 3:30 p.m. with the director of nursing regarding the procedure for administering a nebulizer treatment revealed she agreed the nurses should have been assessing the resident's breathing and pulse before and after the treatment to determine effectiveness and they had not followed their procedure.</p> <p>Review of the provider's revised February 2005 Nebulizer Procedure revealed: *"Note pre-treatment data such as pulse and breath sounds." *"Note post-treatment data (pulse, breath sounds, and any side effects) and record in the medical record. (If pulse is increased more than 20 beats per minute over baseline, notify physician.)."</p>	F 281			

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to accurately assess one of one sampled resident (6) who smoked to determine he was safe to: *Smoke cigarettes on his own. *Keep the cigarettes and lighter with him. Findings include:</p> <p>1. Observations on 6/28/16 at various times from 8:00 a.m. through 5:30 p.m. of resident 6 revealed: *He would leave the facility to go outside, sit on a motorized scooter, ride around, and smoke cigarettes. *He had kept the cigarettes and lighter in his shirt pocket. *Observation that same day at 5:30 p.m. showed burn holes in the seat of the scooter. *He was not wearing a smoking apron to protect himself. *He was not supervised when smoking.</p> <p>Review of resident 6's medical records revealed: *Diagnoses including dementia with behavioral disturbances, depression, and anxiety.</p>	F 323	<p>F323</p> <p>Resident 6's smoking assessment was reviewed to ensure resident is determined safe to smoke independently and handle and store smoking materials. *See page 6 NPN/SDDOTHEL All other residents' smoking assessments were reviewed to ensure residents are determined safe to smoke independently and handle and store smoking materials.</p> <p>DON and interdisciplinary team reviewed and revised as necessary the policy and procedure about appropriate assessment for resident safety and independent use of smoking materials. *See page 6 NPN/SDDOTHEL DON or designee will provide education on appropriate assessment for resident smoking safety and independent use of smoking materials on or before July 29, 2016. *to all staff who may be responsible for smoking assessments. NPN/SDDOTHEL</p>	8/18/16	

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F 323	<p>Continued From page 5</p> <p>*He was being treated for the above issues.</p> <p>*His Minimum Data Set assessment showed that he had behaviors such as:</p> <ul style="list-style-type: none"> -Being verbally and physically abusive. -Resisting care. -Agitation. <p>*A 5/4/16 behavioral health physicians' evaluation and management note stated he was "Having some ongoing agitated and aggressive behaviors."</p> <p>*A 6/1/16 physician's treatment progress note mentioned "He continues to be confused and this is worsening."</p> <p>*A 6/27/16 Smoking Safety Screen assessment stated he was safe to smoke without supervision and could keep the cigarettes and lighter with him.</p> <p>Review of resident 6's revised 4/28/16 care plan revealed:</p> <ul style="list-style-type: none"> *He was a smoker, and he had been determined safe to smoke independently. *Observe clothing and skin for signs of cigarette burns. *He was able to light his own cigarette. His cigarettes and lighter would be kept in his shirt pocket. <p>Interview on 6/28/16 at 3:00 p.m. with licensed practical nurse F regarding resident 6's smoking revealed:</p> <ul style="list-style-type: none"> *He did keep his lighter with him. *The motorized scooter belonged to him. *He was allowed to ride his scooter downtown by himself with his cigarettes and lighter. <p>Interview on 6/29/16 at 1:35 p.m. with physical therapy assistant G regarding resident 6 revealed:</p>	F 323	<p>DON or designee will present findings from these audits at the monthly QAPI meetings for review.</p> <p><i>*resident to reassessed and has not been deemed safe to smoke independently. Resident 6 is on a supervised smoke schedule, not allowed to handle or store smoking material and a smoking apron must be used.</i></p> <p><i>NPIN/SDDOHHIEL</i></p> <p><i>*DON or designee will provide education to all staff on resident safety awareness while smoking on or before July 29, 2016.</i></p> <p><i>NPIN/SDDOHHIEL</i></p>		

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F 323	<p>Continued From page 6</p> <p>*The motorized scooter belonged to the resident. *He agreed the resident had been assessed by their department to be safe to ride the motorized scooter by himself. *He stated he had noted burn holes on his clothing in the past.</p> <p>Interview on 6/29/16 at 3:30 p.m. with the director of nursing regarding resident 6's smoking revealed: *They did a smoking assessment on him quarterly, and the last one had been done on 6/27/16. *They assessed him based on his Brief Interview for Mental Status assessment, which had showed no cognitive impairment. -They had not taken his behaviors or other diagnoses into account. *She was unaware there were burn holes in his motorized scooter or on his clothing. *She agreed he might not be safe to carry and smoke cigarettes on his own. *He could have been a danger to himself and others by carrying a lighter.</p> <p>Review of the provider's undated Resident Smoking Policy revealed: *"All residents will be assessed for their safety upon admission by the Charge Nurse or the Director of Nursing. All those who are considered to be unsafe will require a responsible escort and follow the smoking schedule." *"All resident smokers will continue to be re-assessed by the Charge Nurse or the Director of Nursing on a quarterly basis and upon any significant change of health status." *"All smoking material (i.e.: cigarettes, matches, and lighters) will not be allowed to be kept in a resident's room unless deemed appropriate by</p>	F 323		

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F 323	Continued From page 7 the nursing assessment. All tobacco material will be kept in at the nurse's station."	F 323			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	F441 The whirlpool tub and shower room chair was reviewed to ensure appropriate cleaning, disinfecting, and maintenance were completed according to manufacturer's guidelines. * and clear bottle of solution no longer available for use by staff. interdisciplinary team reviewed and revised as necessary the policy and procedure about appropriate cleaning, disinfecting, and maintenance of whirlpool tub and shower chair. DON, infection control nurse, or designee will provide education for all staff responsible for care and maintenance of whirlpool tub and shower chair on or before July 29, 2016. DON, infection control nurse, or designee will audit whirlpool tub and shower chair cleaning once a week for four weeks and monthly for 2 more months to ensure appropriate cleaning, disinfecting, and maintenance is completed according to manufacturer's guidelines.	8/18/16 NPN/POOTHIEL	

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F 441	Continued From page 8 infection. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, manufacturer's guideline review, and policy review, the provider failed to ensure one of one whirlpool tub and shower room chair were appropriately disinfected by one of one certified nursing assistant (CNA) according to manufacturer's guidelines. Findings include: 1. Observation and interview on 6/29/16 at 10:05 a.m. with CNA A during the cleaning and disinfection of the whirlpool tub and shower chair revealed: *She placed the drain plug in the whirlpool tub drain and pressed the disinfect button. *After she saw the disinfectant run through the jets she released the button and pulled out the drain plug. *She immediately rinsed the tub with water and stated she was done. *She then grabbed a clear bottle of solution from the cupboard. *She took the bottle and sprayed the contents on the shower chair. *She immediately wiped the shower chair off with a clean towel. *She had not rinsed off the shower chair or cleaned the under side of the seat. *She performed no handwashing at any time or wore any personal protective equipment (PPE) when she performed the cleaning or disinfection process.	F 441	DON or designee will present findings from these audits at the monthly QAPt meetings for review.	

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F 441	Continued From page 9 Further review and interview after the above observation with CNA A revealed: *The instructions/policy for the whirlpool tub cleaning process were posted on the cupboard in the whirlpool tub and shower room. *The process stopped after Step 6. *Step 6 required the disinfect button to be pressed until the disinfectant solution (Classic Whirlpool Disinfectant Cleaner) came out of the jets, then the button could be released. *She would fill about one quarter of the bottle with the cleaner and fill the remainder with water. *She was unsure how the cleaner was to have been appropriately diluted. *The manufacturer's guideline on the gallon-sized concentrate bottle stated to dilute two ounces of cleaner with one gallon of water. *She was unaware how large her spray bottle was to accurately dilute the concentrated cleaner. *There was no manufacturer's label on the bottle describing instructions for use, the contents, or chemicals within. *That bottle was to have contained the above cleaner. *She would not routinely perform hand hygiene or wear a gown or gloves. *She was unaware the cleaner needed a ten minute wet contact time according to manufacturer's guidelines located on the concentrate bottle. That amount of time was needed in order to disinfect the whirlpool tub or shower chair in-between resident use. *She was unaware without rinsing off the chair, possible redness, irritation, or a burning sensation with prolonged exposure might have occurred to a resident's skin from the un-rinsed shower chair. *Of the thirty-six residents in the facility, thirty-five used the whirlpool tub and one used the shower chair.	F 441			

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F 441	<p>Continued From page 10</p> <p>*She agreed she had not properly disinfected either the whirlpool tub or the shower chair between resident's use.</p> <p>Interview on 6/29/16 at 10:30 a.m. with the infection control coordinator revealed:</p> <p>*Not all the instructions had remained posted for staff to follow.</p> <p>*She was unsure if they had fallen down or had been removed.</p> <p>*Her expectation was CNA A should have followed all of the manufacturer's guidelines on the cleaner bottle, and the whirlpool tub cleaning and disinfecting instructions/policy posted on the cupboard.</p> <p>*She agreed the disinfectant cleaner bottle needed to be labeled with contents, instructions for use, and any hazards.</p>	F 441		

ORIGINAL

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

PRINTED: 07/14/2016
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2016
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
K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/28/16. Centerville Care and Rehab Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

Jessie Jung

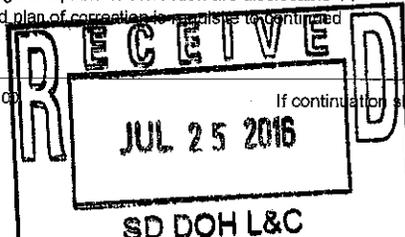
TITLE

administrator

(X6) DATE

7/21/2016

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.



SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/29/2016
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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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(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) COMPLETE DATE
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S 000	<p>Compliance/Noncompliance Statement <i>*Addendums noted with an asterisk per Surveyor: 33488 8/10/16 per email with facility Administrator. NPN/SDDOH/EL</i></p> <p>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/27/16 through 6/29/16. Centerville Care and Rehab Center was found not in compliance with the following requirement: S206.</p>	S 000	<p>S000</p> <p>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:</p>	
S 206	<p>44:73:04:05 Personnel Training</p> <p>The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects:</p> <ol style="list-style-type: none"> (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall 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; (10) Dining assistance, nutritional risks, and hydration needs of residents; and (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. <p>Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.</p>	S 206	<p>S296</p> <p>Employee B no longer employed at facility, unable to complete orientation training on nutritional risks and hydration needs of residents.</p> <p>Education on nutritional risks and hydration needs of residents prepared by Dietary Manager presented to Employee C, D, and E. <i>*on or before 07/29/16 NPN/SDDOH/EL</i></p> <p>All other employee files were reviewed to ensure training on <i>*dining assistance NPN/SDDOH/EL</i> nutritional risks and hydration needs of residents were completed.</p> <p>Administrator and interdisciplinary team to review and revise, create as necessary policies and procedures about Personnel Training.</p>	8/18/16

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

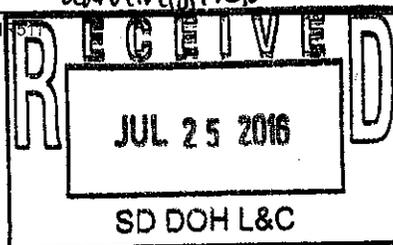
[Handwritten Signature]

TITLE

Administrator

(X6) DATE

7/21/16



SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/29/2016
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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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(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) COMPLETE DATE
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S 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure four of five newly hired sampled employees (B, C, D, and E) had received an orientation program on dining assistance, nutritional risks, and hydration needs of residents. Findings include:</p> <p>1. Review of sampled employees B, C, D, and E's orientation records revealed: *The employees had been hired on the following dates: -Nursing assistant B on 3/3/16. -Housekeeping assistant C on 3/15/16. -Activity assistant D on 4/6/16. -Certified nursing assistant E on 11/11/15. *There had been no documented orientation training on dining assistance, nutritional risks, and hydration needs of residents.</p> <p>Interview on 6/29/16 at 10:30 a.m. with licensed practical nurse F, at 2:10 p.m. with the director of nursing, and at 3:30 p.m. with the administrator and the business manager regarding the above employees orientation training revealed: *The Employee Orientation Checklist was utilized for orientation training for each new employees. -That checklist contained no documentation for orientation training on dining assistance, nutritional risks, and hydration needs of residents. *The administrator expected to have had the state regulation for the orientation training topics for all new employees to have been followed. *They all agreed there was no documentation to show those above listed employees had received</p>	S 206	<p>Business Office Manager or designee will audit all new employee files once per month for three months to ensure orientation training on <i>*dining assistance</i> nutritional risks and hydration <i>NPN/SDDO/HJEL</i> needs of residents were completed.</p> <p>Business Office Manager or designee will present findings from these audits at the monthly QAPI meetings for review. <i>*until audits are completed. NPN/SDDO/HJEL</i></p>	
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SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/29/2016
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) COMPLETE DATE	
S 206	Continued From page 2 orientation training on dining assistance, nutritional risks, and hydration needs of residents. Review of the provider's undated Employee Orientation Checklist revealed the orientation training topic on dining assistance, nutritional risks, and hydration needs of residents was not included for new employees. Review of the provider's undated Personnel Training policy revealed there was to have been a formal orientation program for all personnel that included information regarding dining assistance, nutritional risks, and hydration needs of residents.	S 206			
S 000	Compliance/Noncompliance Statement Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 06/27/16 through 06/29/16. Centerville Care and Rehab Center was found in compliance.	S 000			