STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435088	A. BUILDING _____ B. WING _____	03/15/2023

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

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/12/23 through 3/15/23. Centerville Care and Rehab Center Inc was found not in compliance with the following requirements: F641, F657, F658, F700, F851, F880, and F883.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the accuracy of current diagnoses and resident events had been captured on the Minimum Data Set (MDS) assessment for two of two sampled residents (7 and 28). Findings include: 1. Review of resident 28's medical record revealed she had been admitted on 12/30/22 and on 1/6/23, suffered a hip fracture requiring hospitalization after a fall. Review of resident 28's medical record revealed she: *Was admitted on 12/30/22. *Had multiple falls at home prior her to admission to the facility. *Had a fall with a hip fracture on 1/6/23 resulting in hospitalization. 2. Review of resident 7's 1/20/23, quarterly MDS assessment revealed diagnoses of sepsis and	F 641	Resident 7 & 28 medical records revised and updated by MDS Coordinator. All other residents' MDS will be reviewed and revised before submission to ensure accuracy by DON. Administrator, DON, and interdisciplinary team reviewed revised, and created necessary policies and procedures. DON or administrator will educate staff when policies are changed or at monthly in-service. Signature sheet will provide documentation of education. DON will audit MDSs weekly for 4 weeks and monthly for 2 additional months. DON or designee will report findings at monthly QAPI meetings until audits are complete and issue no longer needs to be assessed.	4/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Peterson	Administrator	4/7/23

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

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F 641	Continued From page 1 pneumonia that had been from his 11/29/21, admission and were no longer current. Review of resident 7's medical record revealed he: *Was admitted on 11/29/21 with diagnoses of sepsis and pneumonia. *He did not have sepsis or pneumonia at the time of the 1/20/23 completion of the quarterly MDS assessment. 3. Interview on 3/14/23 at 12:43 p.m. with MDS coordinator D regarding MDS assessments revealed: *Resident 28's 1/17/23 Admission MDS assessment had not been completed accurately to reflect her history of falls or her fractured hip. *Resident 7 had not had sepsis or pneumonia since admission and should not have been included in the 1/20/23 Quarterly MDS assessment.	F 641	Resident 35's care plan has been revised and updated by SSD. All other residents' care plans will be reviewed, revised, and updated quarterly and as needed with all disciplines and family. SSD, MDS Coordinator, Activities Director, Dietary Manager and DON will update information on care plans.	4/24/23
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657	Administrator, DON, and interdisciplinary team reviewed, revised, and created necessary policies and procedures. MDS Coordinator or MDS Coordinator will educate staff as needed or at monthly in-service. Signature page will provide documentation of education. MDS Coordinator or designee will audit care plans once per week for 4 weeks and monthly for 2 additional months. MDS Coordinator or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be assessed.	

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F 657	Continued From page 2 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure care plans were reviewed and revised to ensure care needs were accurately reflected for one of one sampled resident 35. Findings include: 1. Observation and interview on 3/12/23 at 5:32 p.m. with resident 35 revealed: *She enjoyed living at the facility. *She was treated for cancer on her head on two separate occasions. -She pointed to an area on her forehead and her nose. --Her nose was very small and off to one side of her face. *She had two small children at home. *Her plan was to return home to care for her children. Review of resident 35's medical record revealed: *She was admitted on 7/27/22 and her diagnoses included malnutrition, anxiety, depression, psychosis, and cancer of her nasal cavity. *Her progress notes included a 1/24/23 care	F 657		

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F 657	Continued From page 3 team note that included she wanted to return to her home if she was able. *Her physician orders included a 2/15/23 order to discontinue her feeding tube and start her on a regular diet. *Her 3/12/23 care plan included the following: -Her discharge goal was to remain at the facility long-term. -There was no discharge plan for returning to her home. -She had difficulty eating solid food. -She had a potential for fluid deficit related to poor oral intake. -She used a feeding tube for most of her daily nutrition. Interview on 3/14/23 at 8:29 a.m. with social service director (SSD) L regarding resident 35 revealed: *Resident 35 was "thriving" and was planning on going home. -She had children at home whom she wanted to care for. -She had been working with therapy to walk and become independent in the bathroom before she went home. *SSD L had confirmed she had not updated the discharge care plan for resident 35 to include the above information. *The provider's care plan process was that each member of the interdisciplinary team (IDT) would have updated their specific area of the care plan, IDT met on a quarterly basis and with a significant change in the residents condition. Interview on 3/14/23 at 4:26 p.m. with administrator A regarding care plans revealed: *Care plans had been an issue since the previous recertification survey.	F 657		

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F 657	Continued From page 4 *She thought the residents care plans were updated regularly. *Resident 35 had stopped receiving nutrition through her feeding tube on 2/14/23 and the feeding tube was removed on 3/6/23. *She stated she thought the residents care plans had been updated routinely. *Care plans should have been updated a care conference was held. Review of the provider's June 14, 2019 Comprehensive Care Plan and Care Conferences policy revealed: *"A comprehensive Care Plan will be developed for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial problems, needs and/or strength that are identified in the Comprehensive Assessment." *"Each Resident's care plan will be updated if a goal has been met or if a new focus arises."	F 657	Cannot correct prior non-compliance on monitoring of urine output for resident 4 and bowel output for resident 28. DON will monitor thorough report will be given at shift change by nursing staff and night nurse will adhere to facilities Bowel Program policy. Administrator, DON, and interdisciplinary team reviewed, revised, and created necessary policies and procedures. DON will educate staff as needed or monthly in-service. Signature page will provide documentation of education. DON and or designee will audit physician orders and Bowel Program policy is being followed weekly for 4 weeks and monthly for 2 additional months. DON and or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be assessed.	4/24/23
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to: *Assess and complete documentation for one of one sampled resident (4) who had her Foley catheter removed. *Assess and provide interventions for one of one resident (28) who was constipated.	F 658		

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F 658	Continued From page 5 *Assess two of two sampled residents (7 and 26) to ensure they had been safe to self-administer medications after set-up by nursing staff. Findings include: 1. Observation on 3/12/23 at 3:04 p.m. and on 3/13/23 at 10:13 a.m. of resident 4 revealed she did not have a Foley catheter. Interview on 3/13/23 at 10:23 a.m. with director of nursing (DON) B regarding resident 4 revealed: *The tubing from the Foley catheter had caused a sore on her leg. *The Foley catheter had fallen out a couple of times. *The Foley catheter was removed. Review of resident 4's nurse's notes revealed: *She had been seen by a physician's assistant on 3/2/23 with an order for trial without the Foley catheter and if there was no voiding of urine for eight hours to re-insert the Foley catheter. *On 3/2/23 at 8:57 p.m. a nurse had re-inserted the Foley catheter. *There had been no other nurses notes regarding the Foley catheter that had been removed or any monitoring of resident 4 to ensure she was having adequate urine output. Interview on 3/15/23 at 8:14 a.m. with DON B regarding resident 4 revealed: *On 3/2/23 the nurse who was working was not aware her Foley catheter had been discontinued. -She had re-inserted the Foley catheter without reviewing resident 4's physician's orders. *She was not aware when the catheter had been removed. *The nurses should have communicated the new physician's orders at shift change.	F 658	Cannot correct prior non-compliance of self-administration of medication. Education provided to staff administering medication, policies reviewed and education regarding self-administration of medications. Resident 7 & 26 and all residents will be witnessed taking their medication unless assessed and determined resident is safe to self-administer medications. Administrator, DON, and interdisciplinary team reviewed, revised, and/or created necessary policies and procedures. DON and or designee will audit medication passes weekly for 4 weeks and monthly for 2 additional months. DON and or designee will report findings at monthly QAPI meetings.	

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F 658	Continued From page 6 *The nurses should have documented when the Foley catheter was removed. *The nurses should have documented weather or not resident was having urine output after the Foley catheter was removed. Review of the provider's 9/25/18 Documentation policy revealed: *"To ensure that there is an accurate record of the services provided, client response and ongoing need for care." *"1. All skilled services provided by Nursing, or Social Services will be documented in the clinical record." 2. Review of resident 28's medical record revealed: *On 2/8/23 a nursing progress note was written indicating she has having hard bowel movement when toileted. *There was no follow-up documentation of any interventions that had been initiated regarding her hard bowel movement. Review of resident 28's Bowel and Bladder Elimination record from 2/13/23 through 3/13/23 revealed there was no documentation of a bowel movement for three to five days: *From 2/13/23 through 2/17/23. *From 2/19/23 through 2/21/23. *From 2/25/23 through 2/27/23. *From 3/5/23 through 3/7/23. *From 3/9/23 through 3/13/23. Continued review of resident 28's medical records revealed: *She had physician's orders for two different laxatives to have been administered as needed. *She had not received either laxatives in February	F 658		

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F 658	Continued From page 7 or March 2023. *There had been no documentation of bowel assessments. Interview on 3/14/23 at 10:54 a.m. with registered nurse (RN) E regarding resident 28 revealed: *The night nurse was to review residents who had not had a bowel movement for three days and pass those names onto the day nurse. *The day nurse would then give the resident prune juice and if that had not worked then a laxative would have been administered. *She was not aware resident 28 had not had a regular bowel movement for the last 30 days. *The night nurse had not informed her in the nursing report that any resident had gone three days without a bowel movement. Interview on 3/14/23 at 4:14 p.m. with director of nursing (DON) B regarding resident 28 revealed: *The night nurse was supposed to print the bowel report out of the electronic medical record system. *The day nurse was to administer a medication such as a laxative for the residents who were on that bowel report. *Resident 28 had not had a bowel movement for 5 days and the night nurse who had working on 3/13/23 had not communicated that to the DON who had worked the 3/13/23 day shift. Review of the provider's 10/1/21 Bowel Program policy revealed: *"The night nurse is responsible for printing the bowel report by 0600 [6:00 a.m.]. *The protocol is as follows: -Day 3 with no bowel movement - give milk of magnesia -Day 4 with no bowel movement - give	F 658		

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F 658	Continued From page 8 suppository. *The night nurse is responsible for giving suppositories. *The day nurse/day med [medication] aide can give milk of magnesia in the morning." 3. Observation on 3/14/23 from 7:28 a.m. through 7:34 a.m. of unlicensed assistive personnel UAP M passing medications in the dining room revealed he had: *Prepared medications for resident 7, put them in a plastic medication cup, labeled the cup with resident's first name, and had set the cup down on the table in front of the resident without observing the resident take the medications. *Prepared medications for resident 26, put them in a plastic medication cup, labeled the cup with resident's first name, and had set the cup down on the table in front of the resident without observing the resident take the medications. Interview on 3/14/23 at 7:59 a.m. with UAP M regarding residents 7 and 26 revealed: *He had been instructed those residents had not needed supervision to self-administer medications because they were not confused. *He had a piece of paper in the top drawer of the medication cart with handwritten resident names whom he did not have to watch take medications. Review of resident 7's medical record revealed: *He was admitted on 11/29/21. *His 1/20/23 quarterly Minimum Data (MDS) assessment showed he had a Brief Interview for Mental Status (BIMS) score of 10, indicating his cognition was moderately impaired. *There had not been an assessment to ensure he was safe to self-administer medications after the medications had been set up by nursing staff.	F 658		

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F 658	Continued From page 9 *His initiated 12/27/21 care plan had not addressed self-administration of medications. Review of resident 26's medical record revealed: *He was admitted on 9/8/22. *His 2/23/23 quarterly MDS assessment showed he had a BIMS score of 13, indicating he was cognitively intact. *There had not been an assessment to ensure he was safe to self-administer medications after the medications had been set up by nursing staff. *His initiated 12/6/22 care plan had not addressed self-administration of medications. Interview on 3/14/23 at 8:53 a.m. with DON B regarding resident's 7 and 26 self-administering medications after set-up by the nursing staff revealed: *Both residents were cognitively intact and could self-administer medications after set-up by nursing staff. *She was unsure if either resident had been assessed for safety when self-administering medications. Interview on 3/15/23 at 7:51 a.m. with administrator A revealed the provider did not have a policy on resident self-administration of medications.	F 658		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following	F 700		

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F 700	Continued From page 10 elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure six of six sampled residents (8, 9, 28, 32, 35, and 141) had: *Received the risks versus the benefits education for side rail use. *Obtained a signed informed consent forms for side rail use. *Quarterly assistive safety device assessments completed for side rail use. *Alternatives to side rails were attempted prior to the installation of side rails on the residents beds. Findings include: 1. Observations on 3/12/23 between 3:06 p.m. and 5:30 p.m. and again on 3/13/23 between 8:00 a.m. and 11:00 a.m. of the above sampled resident rooms revealed all those residents had quarter-length side rails on one or both sides of their beds.	F 700	All residents will be assessed for benefit or risk of use of bed rails by MDS coordinator. Bed rail assessment worksheet to determine benefit or risk of bed rail has been implemented. Alternative assistive devices such as bed in lowest position to floor, concave mattress, or body pillow will be used if necessary. All residents will be assessed upon admission, quarterly and as needed. All staff will be educated at 4/19/23 in-service and as needed. Signature sheet will provide documentation of education. Administrator, DON, and interdisciplinary team reviewed, revised, and created necessary policies and procedures. Administrator, DON, or MDS coordinator will educate staff on revised or new policies. Education will be documented on sign-in sheet at in-service or meeting. MDS Coordinator or designee will audit assessments of bed rail use weekly for 4 and monthly for 2 additional months. MDS Coordinator or designee will report findings at monthly QAPI meetings until audits are complete and assessments are being completed upon admission, quarterly or as needed.	4/24/23

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F 700	Continued From page 11 Review of the medical records for the residents identified above revealed the following: *No risks versus benefits education for side rail use had been documented prior to side rail installation *No informed consent for side rail use had been documented prior to side rail installation. *No side rail safety assessments had been completed. *There were no documented alternatives to side rail use prior to the installation of side rails. Interview on 3/13/23 at 5:22 p.m. with Minimum Data Set (MDS) assessment coordinator D regarding side rails revealed: *The side rails were assist devices and were not considered side rails. *All beds have side rails on them. *She had not assessed any of the residents for safety with side rail use, offer alternatives to the use of the side rails, provided education to the residents or their family or representative on the risks verses benefits of the side rails, and had not obtained an informed consent. *She would not have added them to the resident care plans. Interview on 3/14/23 at 4:24 p.m. with director of nursing (DON) B regarding the residents use of side rails revealed the following: *Beds were new since the last survey on 10/20/21. *She had considered the side rails as an assist device. *All of the beds had side rails on them. Interview on 3/15/23 at 1:01 p.m. with administrator A revealed the following: *She was not aware of the what the requirements	F 700		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 12 were prior to installing the side rails on the resident's beds. *Since the side rails held the bed controls, there were no other options but to put the rails on the beds. *She agreed the bed controls would have worked without the side rail and they could find another way to have kept the bed control in reach for those residents who had not required a bed rail. Review of the 7/14/21 revised Bed/Side Rails policy and procedure revealed: *Action Steps included: -Residents were to have been assessed for the appropriateness of the side rails including the consideration of alternatives. -Side rails usage would have been minimal, occurring only when there was a medical necessity that was documented. *Residents who had not needed side rails, would have had the rails removed from the bed.	F 700	Cannot correct prior non-compliance of Payroll Based Journal submission.	4/24/23
F 851 SS=D	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and	F 851	Payroll Based Journal will be submitted to CMS quarterly per regulations requirements by Administrator. Administrator, DON, and interdisciplinary team reviewed, revised, and/or created necessary policies and procedures. Administrator will educate staff on policies changes and signature sheet will provide documentation of education. Administrator will audit electronic submission of Payroll Based Journal quarterly for 2 quarters. Administrator will report findings at monthly QAPI meetings until audit is complete and no longer needs to be assessed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435088	A. BUILDING _____ B. WING _____	03/15/2023

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

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F 851	Continued From page 13 services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.	F 851		

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F 851	Continued From page 14 §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and Certification and Survey Provider Enhanced Reports (CASPER) reporting data review, the provider failed to ensure their Payroll Based Journal (PBJ), (information of the provider's daily staffing hours for the appropriate care of the residents) had been complete and the data had been submitted to the Center for Medicare and Medicaid Services (CMS) for three of three quarters in 2022. Findings include: 1. Review of the provider's CASPER reporting data revealed no PBJ data had been submitted for the time period of: *April 1, 2022 through June 30, 2022. *July 1, 2022 through September 30, 2022. *October 1, 2022 through December 31, 2022. Interview on 3/14/23 at 4:26 p.m. with administrator A regarding submission of PBJ data to CMS revealed she was: *Aware the data had to have been submitted. *Not aware of the "importance until recently". *Not sure how to submit the data.	F 851		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880	All nurses will receive training on hand hygiene during a dressing change and proper handling and disinfection of glucometers. DON has reviewed dressing change policy and identified mistake. Nurse E reviewed updated policy regarding proper handling and cleaning of glucometer. DON will educate, re-educate, and provide training to all nurses by 4/12/23.	4/12/23

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F 880	Continued From page 15 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880	Administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for hand hygiene during dressing changes and cleaning and maintenance of glucometer between residents. All residents and staff have the potential to be affected by lack of: Appropriate processes and follow through for the above identified items. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 4/12/23 by DON. Root cause analysis was conducted and concluded the root cause of hand hygiene during dressing change is lack of habit and adherence to policy. DON was nervous being watched and was not prepared properly, DON identified mistake during dressing change and was unsure if she should make the correction in front of surveyor. Root cause analysis conducted on proper handling of glucometer and concluded using a barrier was not included in policy. Proper disinfection of front and back of glucometer should have been completed by nurse E. Administrator, DON, medical director, and any others identified as necessary will ensure all facility staff responsible for the assigned tasks have received education/training with demonstrated competency and documentation.	

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F 880	Continued From page 16 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure infection prevention and control practices had been maintained for the following: *Hand hygiene during one of one observed dressing change by one of one director of nursing B. *Handling and cleaning of a glucometer by one of one registered nurse (E) during use for one of one observed resident (16). Findings include: 1. Observation on 3/13/23 at 1:52 p.m. of DON B performing a dressing change for resident 8 revealed: *She had gathered dressing supplies, performed hand hygiene, and put on a pair of clean gloves while she was at the nurses station.	F 880	Administrator met with Lori Hintz virtually 3/31/23 and discussion included using a tote or designated area for all dressing change supplies and making sure all supplies are accessible before starting the dressing change. Hand sanitizer could be added to tote to ensure proper hand hygiene during glove changes. Glucometer policy and procedures will be revised and updated and education to appropriate staff will be provided. Use of cue work like "Sally is here" is a way to remind staff about hand hygiene. Administrator, DON, and/or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to tice monthly for 1 month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee at monthly QAPI meetings and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 17 *She walked down the hall into resident 8's room. *She held the dressing supplies in her left hand while she picked up and moved the fall mat that had been on the floor next to the resident's bed and moved the bed away from the wall. *Without performing hand hygiene or changing her gloves she: -Pulled back the resident's bedding to expose her right lower leg, put down a clean a clean disposable pad on the bed, and set her dressing supplies on top of it. -Removed residents protective boot and sock from her right foot. -Started to removed the resident's dressing from her right heel. -Walked across the room to get a bottle of wound cleansing spray to put on the dressing to help loosen the dressing from the wound. -Removed the dressing with those same gloved hands. *Went into the resident's bathroom, removed her gloves, and without performing hand hygiene placed a new pair of gloves on her hands. *Returned to the bedside, cleansed the wound, applied Betadine, and covered it with a gel padded sock. Interview on 3/14/23 at 4:30 p.m. with DON B regarding resident 8's dressing change revealed she: *Had been the charge nurse on 3/13/23. *Had not thought removing the dressing with her gloves would have put the resident at risk for infection because it was a dirty dressing. *Had not washed or sanitized her hands between glove use because it was too hard to put new gloves on when her hands were damp. Review of the provider's 10/9/17 Hand Hygiene	F 880		

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F 880	Continued From page 18 and Handwashing policy revealed hand hygiene should hade been performed after removing gloves. Review of the provider's February 2021 Wound Care policy revealed: *To perform hand hygiene before positioning the resident. *After removing the old dressing remove the gloves and perform hand hygiene. 2. Observation on 3/14/23 at 10:54 a.m. with RN E performing a blood glucose check for resident 16 revealed: *The facility had two glucometers that had been shared between the residents. *She had not used a barrier under the glucometer on top of the medication cart or in resident 16's room on the bedside table. *She only disinfected the front surface of the glucometer and not the entire surface of the glucometer. Interview on 3/14/23 with RN E directly after the above observation revealed she: *Was not aware she should have used a barrier under the glucometer while performing resident blood sugar checks. *Agreed the top of the medication cart and resident 16's bedside table had not been cleaned and could have been contaminated. *Agreed she had only wiped the front surface of the glucometer with the disinfecting wipe. Interview on 3/14/23 at 4:30 p.m. with DON B regarding the observation of RN E performing a blood glucose check for resident 16 revealed: *The use of a barrier under the glucometer when performing resident blood sugar checks was not	F 880		

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F 880	Continued From page 19 in the facility's policy. *The entire surface of the glucometer should have been cleaned with the disinfecting wipe. Interview on 3/15/23 at 11:24 a.m. with MDS coordinator D revealed: *She was also the infection control nurse. *Expected all staff to perform hand hygiene prior to removing a dressing and when changing gloves. *She had completed a training on the use of glucometers in September 2023. *Nurses had been educated to use a barrier under the machine and to disinfect the entire surface of the machine after each resident use. Review of the provider's February 2021 Blood Sugar Monitoring policy revealed: *"Do not set the glucometer down anywhere with out a barrier (towel, paper towel)." *"Disinfect monitor after each use using Sani-Cloth."	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 883	Additional dose of immunization has been offered to residents 19, 21, and 28. Consent or refusal form has been signed and documented. All residents 65 or older will be offered additional dose of pneumococcal vaccination and all other necessary vaccinations. Consent or refusal form will be signed and documented upon admission or as needed. Administrator, DON, and interdisciplinary team reviewed, revised, and/or created necessary policies and procedures. MDS coordinator will audit immunization weekly for 4 weeks and monthly for 2 additional months.	4/24/23

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F 883	Continued From page 20 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical	F 883		

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F 883	Continued From page 21 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, and Centers for Disease Control and Prevention (CDC) recommendations, the provider failed to ensure three of five randomly sampled residents (19, 21 and 28) had documented pneumonia vaccination administration or the refusal of the vaccine in their medical records. Findings include: 1. Review of resident 19's medical record revealed: *He had been admitted on 12/16/22. *He was 81 years old. *He had a pneumococcal polysaccharide vaccine on 3/10/17. *There was no documentation of the administration or the refusal of a pneumococcal conjugate vaccine. Review of resident 21's medical record revealed: *She had been admitted on 6/5/20. *She was 92 years old. *She had a pneumococcal polysaccharide vaccine on 10/22/15 and on 11/11/21. *There was no documentation of the administration or the refusal of a pneumococcal conjugate vaccine. Review of resident 28's medical record revealed: *She had been admitted on 12/30/22. *She was 93 years old. *She had pneumococcal polysaccharide vaccine on 10/7/14. *There was no documentation of the administration or the refusal of a pneumococcal conjugate vaccine.	F 883		

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F 883	Continued From page 22 2. Interview and review on 3/15/23 at 11:08 a.m. of the CDC's recommendation for pneumococcal vaccine timing for adults with Minimum Data Set (MDS) assessment coordinator D revealed she: *Was the infection control nurse. *Reviewed resident vaccinations at the time of admission and was responsible to ensure all residents were up to date. *Had not known more than one pneumonia vaccine was recommended by the CDC. *Had a copy of the CDC's 2/8/23 Pneumococcal Vaccine Timing for Adults diagram. 3. Review of the provider's February 2021 Pneumococcal Vaccine policy revealed: "1. Current and newly admitted residents will be assessed for eligibility to receive the vaccines, when indicated they will be offered the pneumococcal vaccinations within 30 days of their admission (as of 1/20/20)."	F 883		

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities, was conducted from 3/12/23 through 3/15/23. Centerville Care and Rehab Center Inc was found in compliance.	E 000		

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

Amanda Peterson | Administrator | 4/7/2023

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.

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

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	435088	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/13/2023

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/13/23. Centerville Care and Rehab Center Inc was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills) for two of four yearly quarters from January through December 2022 and October through December 2021. Two evening shift drills had been documented for the	K 712	Cannot correct prior non-compliance of completion of fire drills of each shift. All residents and staff have been affected. A schedule has been made to ensure competition of fire drills for all shifts. At a minimum fire drill will be completed for each shift once per quarter. Administrator, maintenance director, and interdisciplinary team reviewed, revised, and/or created necessary policies and procedures. Maintenance director and/or designee will audit completion of fire drills monthly for 1 quarter and 1 additional quarter. Maintenance director and/or designee will report findings at monthly QAPI meetings.	4/26/23

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

Amanda Peterson | Administrator | 04/07/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435088	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 1 first quarter and the third quarter in 2022 (January 20 and September 29). Findings include: 1. Record review on 3/13/23 at 1:00 p.m. revealed the provider had a three-shift staffing schedule (First shift: 6 a.m. to 2 p.m.; Second shift: 2 p.m. to 10 p.m.; and Third shift: 10 p.m. to 6 a.m.). There was no documentation of the day or evening shift fire drills for October, November, or December, 2022. There was no documentation of the fire drills for the third shift from February through August, 2022. Drills were held for the third shift in January and September 2022. There was no documentation a fire drill had been held in the fourth quarter of 2022 on the second or third shifts. Fire drills for a three-shift system must be held on one drill per shift per quarter, at a minimum. Interview with the Administrator at the time of the record review confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		

South Dakota Department of Health

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	10605	A. BUILDING: _____ B. WING _____	03/15/2023

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

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/12/23 through 3/15/23. Centerville Care and Rehab Center Inc was found not in compliance with the following requirement: S301.	S 000		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and policy review, the provider failed to ensure required dietary training for food safety, handwashing, food handling/preparation, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, and sanitation had been completed annually for five of five sampled dietary staff members (G, H, I, J, and K). Findings include: 1. Based on interview and policy review, the provider failed to ensure training for State required dietary and food-handling topics had been completed since the time of the 10/20/21 licensure survey for five of five sampled dietary staff members (G, H, I, J, and K). Findings include:	S 301	Staff G,H,I,J,K will have completed required dietary training by 4/10/2023 and all other staff will be provided with required annual dietary training by Dietary manager on 4/19/23. All topics of required dietary in-service training will be included in upcoming in-service for all staff. Signature page will provide documentation of education. Administrator, Dietary Manager, and interdisciplinary team reviewed, revised, and created necessary policies and procedures. Dietary Manager will implement new or updated policies and provide dietary staff education on policies. All other staff will be educated at monthly in-service by dietary manager or administrator. Dietary Manager and/or designee will audit new hire dietary training weekly for 4 weeks and monthly for 2 additional months. Dietary manager or designee will report findings at monthly QAPI meetings until audits are complete and regulation has been met.	4/26/23

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10605	A. BUILDING: _____ B. WING _____	03/15/2023

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

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S 301	Continued From page 1 Review of personnel files for dietary staff G, H, I, J and K revealed there was no documentation to support they had received any of the required dietary and food-handling training topics in the past seventeen months. Interview on 3/14/23 at 3:45 p.m. with dietary manager C regarding annual dietary training revealed she was not aware of the requirements of the annual training topics for all dietary employees. Interview on 3/14/23 at 4:28 p.m. with administrator A regarding annual dietary training revealed she was: *Aware that an annual training for nutrition and hydration was required for all employees was required. *Not aware of all the other requirements of annual training topics for all dietary employees. Review of the dietary manager's job description revealed she was responsible to: *"Assure that the dietary department is in compliance with all state, federal and local regulations." *"Conducts in-servicing for the dietary personnel, facility personnel and monthly scheduling." Review of the provider's June 2020 Employee Orientation Policy and Procedure revealed ongoing training was not included in the policy.	S 301		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide	S 000		

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S 000	Continued From page 2 training programs, was conducted from 3/12/23 through 3/15/23. Centerville Care and Rehab Center Inc was found in compliance.	S 000		