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	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centerville Care and Rehab Center Inc	500 Vermillion St Centerville, SD 57014

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45383 Based on interview, record review, policy review, and South Dakota Department of Health (SD DOH) facility reported incident (FRI) the provider failed to ensure two of two sampled residents (1 and 2) had been assessed, care plans were updated, and education was provided to staff regarding having been fondled by a co-located resident (4). Findings include: Notice: Notice of immediate jeopardy was given verbally and in writing on 5/8/24 at 9:10 a.m. to administrator A and regional administrator D of the immediate jeopardy related to resident abuse by a colocated resident at F600 when the provider failed to ensure the following: *A resident assessment, care plan updating, and staff education regarding the fondling of vulnerable residents by a co-located resident. On 5/8/24 at 9:10 a.m. administrator A, regional administrator D, and director of nursing (DON) B were asked for an immediate removal plan. Plan: 1.Centerville Care and Rehab Center understands the severity of this incident and have taken the following actions to provide education to staff and to ensure the safety of our residents. May 6, 2024, 30-minute checks on resident 4 initiated to ensure the safety of all residents. Medical director I discontinued the use of Sildenafil, and will monitor the use of other medications that could lead to sexual temptations. Resident 4 was scheduled to be evaluated by (psychiatry provider) to rule out dementia or other medical conditions that could cause the more frequent sexual behaviors. Resident 4 was seen by (psychiatry provider) 5/7/24. Care plans have been updated. Education was provided to all staff. Managers will provide the education to staff that were not in the building and staff will be required to receive the education before they start their next shift. All staff will continue to monitor behaviors and safety for all residents. Interventions in place will be assessed and will be modified if needed to make sure the issue is being resolved appropriately. On 5/8/24 at 11:53 a.m. the removal plan was received. On 5/8/24 at 12:20 p.m. the provider's immediate jeopardy removal plan was accepted. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/8/24 at 1:20 p.m. while on-site the immediacy was removed. Once the immediacy was removed the scope and severity was changed to a G. Review of SD DOH FRI revealed: *On 5/1/24 at 9:00 a.m. resident 4 was inappropriately touching resident 1 between her legs and she is unable to give consent. *On 5/5/24 at 6:00 p.m. resident 4 had taken resident 2's hand and placed it on his groin. Resident 4 moved resident 2's hand in up and down and rubbing motions. Resident 2 does not talk and cannot defend herself. Interview on 5/6/24 at 9:50 a.m. with registered nurse (RN) E regarding resident 1 being fondled by resident 4 revealed: *She had observed resident 1 sleeping in a recliner near the front entrance. Resident 4 had his hands on her groin area and was rubbing it. He was moving his tongue back and forth in his mouth while he was rubbing resident 1. *She had observed resident 4 rubbing on other residents' thighs on other occasions. *RN E notified administrator A, DON B, and social services designee C of the witnessed event. Interview on 5/6/24 at 10:10 a.m. with certified nursing assistant (CNA) F regarding resident 4 touching female residents revealed: *She had observed resident 4 touching other residents and reported the incidents to the charge nurse. *She had observed resident 4 touching resident 3's breast and reported the incident to the charge nurse. Interview on 5/6/24 at 10:40 a.m. with CNA G regarding resident 4 touching female residents revealed: *She had observed resident 2 walking past resident 4 in his wheelchair, he then touched her on her buttock. *CNA G reported the incident to the charge nurse. *She had been informed by other staff members resident 4 would touch other residents inappropriately. Interview on 5/6/24 at 11:00 a.m. with RN E regarding CNA's reporting of having been inappropriately touched by resident 4 revealed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*She had received reports by CNAs and informed administrator A, DON B, and social services C of the incidents. Interview on 5/6/24 at 11:10 a.m. with administrator A, DON B, and social services C regarding the incidents with residents 1, 2, 3 and 4 revealed: *Administrator A had spoken with resident 4 and had contacted the ombudsman. *DON B stated resident 4's son had spoken with him regarding his behavior. *Administrator A had been aware that resident 4 was targeting non-consenting residents. *Resident 2's son had been notified of the incident with his mother. Administrator A stated her son was very concerned of his mother's safety. *They had not been aware that resident 3 was touched by resident 4. Review of resident 1's electronic medical record (EMR) revealed: *She had a diagnosis of dementia and psychosis. *On 3/27/24 her brief interview for mental status (BIMS) was 2, indicating severe cognitive impairment. *Resident 1's care plan had not been updated to indicate she had been a victim of inappropriate touching. Review of resident 2's EMR revealed: *She had a diagnosis of dementia, amnesia, and trans ischemic attack (TIA). *On 3/11/24 her BIMS score was 99, indicating the interview assessment is not successful. *Resident 2's care plan had not been updated to indicate she had been a victim of inappropriate touching. Review of resident 3's EMR revealed: *She had a diagnosis of Alzheimer's disease and dementia. *On 3/11/24 her BIMS score was 99, indicating the interview assessment is not successful. *Resident 3's care plan had not been updated indicate she had been a victim of inappropriate touching. Review of the provider's June 2021 Abuse and Neglect Policy and Procedure revealed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*To ensure that the center has in place and effective system that regardless of the source prevents mistreatment, neglect and abuse of residents of misappropriation of their property. *To ensure that resident are not subject to abuse by anyone, including, not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals. *To ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated and reported. *All staff are responsible for reporting any situation that is considered abuse, neglect, or injury of unknown origin, misappropriation of resident property or involuntary seclusion. *The charge nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required, and complete an initial investigation. If this is an injury of unknown origin, the charge nurse will also attempt to determine the cause of the injury. The charge nurse will also ensure that any potential for further abuse is eliminated by taking on of the following actions: -If it is resident to resident abuse, the abused resident will be removed to a safe environment. *Notification Procedure: -Notify the center administrator immediately of any incident of resident abuse. -Notify the designated agencies in accordance with state law, including the state survey and certification agency. -If the agencies require an online report to be submitted contact the Social Services Designee, DON, and Administrator. -Notify the physician and family regarding the facts of the situation. If there is alleged or suspected abuse/neglect or an injury of unknown origin, inform them that an investigation is in process.