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	05/21/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on South Dakota Department of Health (SD DOH) complaint intake review, interview, and policy review, the provider failed to report an allegation of suspected abuse for one of one sampled resident (27). Findings include: 1. Review of a 12/31/24 SD DOH anonymous complaint intake report revealed: *On 12/19/24 the anonymous writer was told by certified nursing assistant (CNA) F that resident 27 was inappropriately touched on the breast by certified medication aide (CMA)/CNA G. *CMA/CNA G tried holding resident 27's hands behind her back. *CNA F had reported the allegations, but thought nothing had been done. 2. Review of resident 27's electronic medical record revealed: *She had a diagnosis of Alzheimer's disease. *Her Brief Interview for Mental Status assessment score was 03 indicating severe cognitive impairment. 3. Interview on 5/19/25 at 9:59 a.m. with resident 27's family member revealed: *She had been told of the allegations of suspected abuse. *She did not believe the accusations. *She felt the provider was transparent about their investigation of the allegation. *She thought CMA/CNA G was wonderful, and she was upset he no longer worked at the facility. Interview on 5/19/25 at 1:17 p.m. with CNA F revealed: *ON the morning of 12/19/24, she was assisting resident 27 in getting up and ready for the day. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Resident 27 was lying across the bed with her legs hanging over the side of the bed and her walker in front of her. *Resident 27's brief was not pulled up and her pajama top was off. *CMA/CNA G came into the room to assist with resident 27. -He jumped on the bed. -His leg was across resident 27's body. -He placed his hand on her inner left thigh. -He rubbed her left shoulder area. -He said resident 27 was his girlfriend. -He said, Let's get you dressed. -CMA/CNA G's hand rubbed along the left side of the resident's breast. *CNA F told CMA/CNA G she would finish with assisting resident 27. *CMA/CNA G then left the room. *CNA F reported the allegation of suspected abuse to registered nurse (RN) H that day. *She reported the allegation to former administrator O on 12/20/24. Interview on 5/19/25 at 3:38 p.m. with RN H revealed: *CNA F had reported the above allegation of suspected abuse for resident 27 to her on 12/19/24. *She told her to report it to former administrator O as she was in the facility on 12/19/24 per provider's policy. *She had received education regarding abuse and neglect in the summer of 2024. Interview on 5/21/25 at 8:34 a.m. with social services designee (SSD) P revealed: *She or former administrator O complete the state reporting documents for the provider for any concerns with potential abuse or neglect. *She would report any abuse allegations within 24 hours to SD DOH, law enforcement and ombudsman. *If immediate jeopardy she would report within two hours to the state. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She assumed former administrator O had completed the initial report to the state as she was who investigated the allegation regarding resident 27 in December 2024. *SSD P stated she was not involved in the investigation for the above allegation regarding resident 27. Interview on 5/21/25 at 8:45 a.m. with director of nursing (DON) B revealed: *She was notified of the above allegation regarding resident 27 on 12/23/24 by former administrator O. *She became involved in the allegation investigation by conducting interviews with CNA F and CMA/CNA G on 12/23/24. *CMA/CNA G was suspended during investigation. *She assumed the state report had been completed on 12/20/24 when CNA F reported it to former administrator O. *Investigation was inconclusive in findings of allegation of abuse. Interview on 5/21/25 at 9:21 a.m. with emergency permit holder (EPH) administrator A revealed: *She was hired on 1/20/25. *She expected allegations of abuse to be reported to SD DOH within 24 hours, and if there were immediate concerns to the resident those should have been reported within two hours. *She confirmed allegation should have been reported. *She and SSD P complete the state reporting for the provider. 4. Review of the provider's revised 5/20/24 Abuse and Neglect Policy and Procedure revealed: *b. Notify the designated agencies in accordance with state law, including the state survey and certification agency. You may need to notify more than one agency in order to fulfill federal and state regulations. If the agencies require an online report to be submitted contact Social Services Designee, DON, or the Administrator. *8. The social worker will report the results of all investigation to the state agency and other officials within five (5) working days of the incident, unless otherwise specified by state law, whichever is stricter.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure adequate supervision for one of one sampled resident (18) identified at risk for wandering to prevent him from leaving the building without staff knowledge or supervision. Failure to provide supervision while the resident was outside of the building put the resident at risk for potential accident and/or injury. This citation is considered past non-compliance based on the provider's corrective actions implemented following the incident. Findings include: 1. A review of the 5/15/25 SD DOH FRI regarding resident 18 revealed: *He had eloped (left the building without staff knowledge) from the facility without staff knowledge or supervision on 5/14/25 at approximately 6:15 p.m. *He had a Brief Interview for Mental Status (BIMS) assessment score of 4, which indicated he had severe cognitive impairment. *He had a history of exit-seeking but had not exited previously without staff supervision. *He frequently believed the building across the road was his hotel or apartment. *Staff believed he was outside for three to four minutes prior to them responding to the door alarm and locating him in front of the building. *He returned to the building with the assistance of staff and their assessment found no harm or injury. 2. Observation and interview on 5/18/25 at 4:45 p.m. with resident 18 in his room revealed: *He was able to answer basic questions but displayed confusion with his responses. *He stated he did not need to call staff for assistance, but he could go to the door and call out for them. *He was unaware that he had a call light to use to call the staff for assistance. *When it was pointed out to him, he was unclear what it was or why to use it. *He was independent in moving around the facility with his walker with a shuffling gait (a walking pattern characterized by dragging the feet instead of lifting them, often with short, quick steps). *He spent most of each day in the dining room near the activities area. *He had no recollection of leaving the building on 5/14/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/20/25 at 1:27 p.m. with resident 18's spouse revealed: *She spent Tuesday afternoons with him playing bingo at the facility. *His cognition had continued to decline to the point that she wondered if he had been reading the materials he had with him or was just making the motions. *He often did not interact with her when she was there with him but he would actively participate in an activity. *She felt the facility had enough staff to take care of him. *She was not concerned with the staff's ability to keep him safe after his elopement the week prior. Interview on 5/20/25 with registered nurse (RN) W revealed: *She worked the night shift on 5/14/25 when resident eloped from the facility. *She was in a resident's room when she heard the door alarm sounding. *When it continued to sound, she left the resident's room, checked the alarm panel and proceeded to the front door. *She observed resident 18 walking away on the sidewalk that ran against the front of the building. He was approximately 35 feet from the front door. *She called for staff assistance and with certified nursing assistant (CNA) U, was able to assist resident in returning to the building. *He was assessed and had no injury or indictors of harm from leaving the building unattended. *She estimated he was outside, unsupervised, for three to four minutes. *He had no further exit-seeking behaviors that evening. *She educated the staff working that shift to closely supervise him and to respond to the door alarm immediately if it sounded. *She stated he often looked out the doors but did not exit the building unattended. *Resident 18 often would get increasingly confused in late afternoon and evening, thinking he needed to get to his apartment. *She felt they had enough staff and interventions in place needed to keep the residents safe. Interview with Director of Nursing (DON) B revealed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She was notified by RN W of resident 18's elopement on 5/14/25. *She educated RN W on their elopement policy at that time. *Resident 18 was placed on one-hour safety checks after his elopement on 5/14/25. *She spoke with staff throughout the building over the next several days about interventions they could use when resident 18 was confused about needing to leave the building. *She expected all staff to respond to the door alarm if it sounded. *Facility doors were alarmed, but they were not able to add a wander guard system due to the type of wiring at the facility. *A tab alarm (motion alerting device) was not an intervention option for resident 18 due to his mobility and sensitivity to alarms. *Loud noises such as the fire alarm upset him and caused him increased confusion. *She felt that they had interventions and adequate staff to keep residents safe. Interview and record review on 5/21/25 at 10:17 a.m. with emergency permit holder (EPH) administrator A revealed: *Resident 18 had been placed on hourly safety checks following his elopement. *A notice had been posted for staff on 5/18/25 that resident 18 was at risk for elopement. *Door alarm audits for response to alarms were initiated on 5/16/25 and would continue for three months for timely response to door alarms. *Review of door alarm audits completed from 5/16/25 to 5/21/25 confirmed appropriate staff response with all response times of 62 seconds or less. *Resident 18's care plan had been updated on 5/19/25 to include the hourly safety checks and interventions for exit-seeking behavior. *A staff in-service was held on 5/20/25, where reeducation was provided on caring for residents with unique needs and exit-seeking, along with the elopement and door alarm policies. *Documentation of staff attendance and education materials confirmed that the training has occurred. Review of resident 18's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *His diagnoses included: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Parkinson's Disease. -Depression. -Unspecified Dementia. *He had a BIMS assessment score of 4. *A wandering risks scale completed on 3/21/25 had a score of 11, which indicated that he was at high risk to wander. *He was placed on one-hour safety checks as an intervention after his 5/14/25 elopement. Review of resident 18's care plan revealed: *A focus area initiated on 5/19/25 I am a elopement risk/wanderer r/t (related to) history of attempts to leave facility unattended. *The goal initiated that date was my safety will be maintained through the review date. *Interventions included: -Anticipate my needs for going outside. -If I try to go outside unsupervised, please walk with me until I am ready to return to the facility. -Answer door alarms promptly. -Hourly checks. -Offer diversions, structured activity, food, conversation. Review of the provider's 2/24/24 door alarm policy revealed: *All exit door alarms are to remain on at all times. *It is the responsibility of all staff to answer any sounding alarm and check outside of the door of where the alarm sounded. Review of the provider's elopement policy updated May 2025 revealed: *A definition of elopement as when a resident who requires supervision leaves the premises or a safe area without authorization and/or any necessary supervision to do so. *The provider will be responsible for completing an elopement risk assessment to know who is at risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Provide appropriate interventions once a residents identified as being at risk for elopement. *Door alarms will be answered promptly. *Staff will investigate why the door is alarming. Based on the above information, non-compliance at F689 occurred on 5/14/25, and based on the provider's implemented corrective action for the deficient practice confirmed on 5/21/25, the non-compliance is considered past non-compliance.