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	06/10/2026

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to protect the residents' right to be free from physical abuse for one of one sampled resident (1) who was pinched and scratched on her hand by one of one certified nursing assistant (CNA) D while she was assisting resident 1 to eat.Findings include: 1. Review of the provider's 4/3/26 SD DOH FRI revealed that on 4/2/26 at 6:10 p.m., CNA D pinched and scratched resident 1 on her right hand. CNA D reported to licensed practical nurse (LPN) C that resident 1 asked CNA D to pinch her. LPN C asked resident 1 if CNA D pinched and scratched her and resident 1 replied that she had. LPN C noticed bruising where the resident pointed to indicating where CNA D had pinched her. Administrator A was notified and CNA D was immediately suspended pending an investigation. CNA D was later terminated from employment due to physical harm.2. Review of resident 1's electronic medical record (EMR) revealed that she admitted to the facility on [DATE]. Her medical diagnoses included dementia (a decline in mental ability that affects memory, communication, and behavior) with behavioral disturbances. Her 3/17/26 Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated her cognition was moderately impaired.3. Interview on 6/10/26 at 11:25 a.m. with administrator A revealed that she did not interview CNA D after the incident with resident 1 on 4/2/26. LPN C and CNA D gave written statements about the incident. Administrator A indicated that CNA D was given a final warning a few months before the incident due to substandard work performance. Administrator A did not know if resident 1 had any aggressive behavior issues. She reported that social services designee (SSD) E indicated that resident 1 previously had aggressive behaviors but had been receiving behavioral health services.4. Interview on 6/10/26 at 12:20 p.m. with director of nursing (DON) B revealed that I would take [resident 1] for her word. CNA D could be very anxious resulting in a short temper. DON B indicated that CNA D had previously been disciplined for an accusation of being rough with resident 2 on 9/11/25. That accusation could not be confirmed due to resident 2's diminished cognitive status and combative behavior. CNA D was given a final written notice on 9/11/25 in her employee file following the accusation and could no longer provide cares to resident 2.5. Interview on 6/10/26 at 1:10 p.m. with CNA F revealed that she was working on the day of the reported incident between resident 1 and CNA D, but she did not witness it. CNA F could not recall ever witnessing CNA D mistreating any residents.6. Interview on 6/10/26 at 2:10 p.m. with SSD E revealed that CNA D was known to be very anxious. CNA D's speech was difficult to understand and sounded like she mumbled when she spoke. She stated that residents with mentation issues would get frustrated with her.7. Review of LPN C's written statement from 4/2/26 at 7:00 p.m. revealed that on the day of the incident, she witnessed CNA D pushing resident 1 in her wheelchair from the dining hall. CNA D approached LPN C and quietly stated She wanted me to pinch and scratch her. The statement indicated that resident 1 began to wave LPN C over to her. [Resident 1] proceeded to show me her right hand. There was small bruised areas that appeared like they could be from a fingernail. Then the top of her left hand had a lg [large] round bruised area. [Resident 1] stated 'See she did this.' Then [resident 1] proceeded to put her (continued on next page)

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.

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

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(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 - Actual harm Residents Affected - Few	finger up over her lips and said 'I don't want to cause any trouble but she did it.8. Review of the written statement from CNA D written on 4/2/26 revealed She (resident 1) had got my arm and was digging her nails in my arm she had left marks. I gentle [gently] grab her arm to take if off. Than [then] she was saying pintch [pinch] me, grab me, starch [scratch] me bruise me. I had said no like 20x than [then] I tell someone to go get here [her].9. Review of CNA D's employee file revealed that on 9/11/25, a counseling form stating a final warning before termination of employment for reasons that included 1. Unable to follow orders from supervisor. 2. Lack of respect from [for] supervisor. 3. Not completing work appropriately related to bed time cares. 4. Complaints from residents-how you handle them-Feel your [you are] a little rough-with their cares.10. Review of the provider's 2/17/26 meeting sign-in sheet with a topic of Nurses/CNA-Abuse/Neglect revealed that CNA D acknowledged receiving education on abuse and neglect.11. Review of the provider's 3/24/26 nursing assistant job description revealed Observes and reports changes in resident's condition to the charge nurse, handles and treats residents in a manner conductive to their safety and comfort, adheres to instructions issued by the nurse and to established routine, and performs duties in accordance with established methods and techniques and in conformance with recognized standards.12. Review of the provider's 8/22/25 Abuse and Neglect Policy and Procedure revealed a purpose To ensure that the center has in place an effective system that regardless of the source prevents mistreatment, neglect, and abuse of residents or misappropriation of their property. To ensure that residents are not subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving individual, family members or legal guardians, friends or other individuals.