STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435088	A. BUILDING _____ B. WING _____	**10/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, phone interview, record review, and policy review, the provider failed to ensure 10 of 14 sampled residents (1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) who had tested positive with Covid-19 had been: *Routinely screened for Covid-19 symptoms prior to testing positive. *Assessed for worsening symptoms of Covid-19 after testing positive. Findings include: 1. Interview on 10/7/20 at 11:30 a.m. with director of nursing (DON) A, administrator B, and infection control (IC)/registered nurse (RN) C revealed: *The Covid-19 outbreak began on 9/30/20 when an employee reported Covid-19 symptoms and was tested on that day. *Employees had been screened routinely prior to each shift. *All residents were screened daily for symptoms of Covid-19. *All resident screening and assessments were documented in each resident's medical record. 2. Review of resident 1's medical record revealed: *His progress notes: -Indicated he had tested positive for Covid-19 on 10/6/20. --The above entry was the last entry in his progress notes. -Had no documentation of having had a physical assessment completed before or after he was tested for Covid-19. *His most recent blood pressure was obtained on 10/5/20. *His temperature had not been monitored on 10/3, 10/4, 10/6, or 10/7. *The last oxygen saturation was obtained on 8/23/20 and was normal. *There was no documentation of a respiratory assessment. 3. Review of resident 2's medical record revealed:*Her progress notes: -Indicated she had tested positive for Covid-19 on 10/6/20. --The above entry was the last entry in her progress notes. -Had no documentation of having had a physical assessment completed before or after she was tested for Covid-19. *Her most recent blood pressure was obtained on 8/18/20. *Her temperature had not been monitored on 10/3, 10/4, 10/6 or 10/7. *The last oxygen saturation was obtained on 8/19/20 and was normal. *There was no documentation of a respiratory assessment. 4. Review of resident 3's medical record revealed: *Her progress notes: -Indicated she had tested positive for Covid-19 on 10/6/20. -Last entry was on 10/6/20. -Had no documentation of having had a physical assessment completed before or after she was tested for Covid-19. *Her most recent blood pressure was obtained on 10/5/20. *Her temperature had not been monitored on 10/3, 10/4, 10/6, or 10/7. *The last oxygen saturation was obtained on 10/5/20 and was normal. *There was no documentation of a respiratory assessment. 5. Review of resident 4's medical record revealed: *Her progress notes: -Indicated she had tested positive for Covid-19 on 10/6/20. -Last entry was 10/6/20. -Had no documentation of having had a physical assessment completed before or after she was tested for Covid-19. *Her most recent blood pressure was obtained on 10/5/20. *Her temperature had not been monitored on 10/3, 10/4, 10/6, or 10/7. *The last oxygen saturation was obtained on 8/19/20 and was normal. *There was no documentation of a respiratory assessment. 6. Review of resident 5's medical record revealed: *His progress notes: -Indicated he had tested positive for Covid-19 on 10/6/20. -Last entry was 10/6/20. -Had no documentation of having had a physical assessment completed before or after he was tested for Covid-19. *His most recent blood pressure was obtained on 10/5/20. *His temperature had not been monitored on 10/3, 10/4, or 10/6. *The last oxygen saturation was obtained on 9/16/20 and was normal. *There was no documentation of a respiratory assessment. 7. Review of resident 6's medical record revealed: *Her progress notes: -Indicated she had tested positive for Covid-19 on 10/5/20. -Last entry was on 10/6/20. -Had no documentation of having had a physical assessment completed before or after she was tested for Covid-19. *Her most recent blood pressure was obtained on 10/1/20. *Her temperature had not been monitored on 10/3, 10/4, 10/6, or 10/7. *The last oxygen saturation was obtained on 9/19/20 and was normal. *There was no documentation of a respiratory assessment, although the physician had been contacted for a nebulizer and cough drops. 8. Review of resident 7's medical record revealed: *His progress notes: -Indicated he had tested positive for Covid-19 on 10/5/20. -Last entry was on 10/7/20. -Indicated he was being treated with antibiotics for a surgical infection. *His temperature had been monitored daily for the surgical incision infection. *There was no documentation of him having had a physical assessment other than for his hip infection completed before or after he was tested for Covid-19. *His most recent blood pressure was obtained on 10/5/20. *The last oxygen saturation was obtained on 9/9/20 and was normal. *There was no documentation of a respiratory assessment. 9. Review of resident 8's medical record revealed: *His progress notes: -Indicated he had tested positive for Covid-19 on 10/6/20. -Last entry was on 10/6/20. *On 10/3/20 he reported he had clammy skin. The nurse documented his skin was warm and dry. His temperature was 97.9 degrees Fahrenheit. *Their was no documentation of him having had a physical assessment after he was tested for Covid-19. *His most recent blood pressure was obtained on 9/18/20. *His temperature had not been monitored on 10/4, 10/6, or 10/7. *The last oxygen saturation was obtained on 9/18/20 and was normal. *There was no documentation of a respiratory assessment. 10. Review of resident 9's medical record revealed: *Her progress notes: -Indicated she had tested positive for Covid-19 on 10/6/20. -That was the last entry. -She had a five minute unresponsive spell on 10/2/20. The documentation at 4:13 p.m. indicated the nurse did not know if the unresponsiveness was caused by a [MEDICAL CONDITION]. No vital signs had been documented. -Had no documentation of having had a physical assessment before or after she was tested for Covid-19. *Her most recent blood pressure was obtained on 9/30/20. *Her temperature had not been monitored on 10/3, 10/4, 10/6, or 10/7. *The last oxygen saturation was obtained on 9/23/20. That oxygen saturation was 89% on room air. *There was no documentation of a respiratory assessment. 11. Review of resident 10's medical record revealed: *Her progress notes: -Indicated she had tested positive for Covid-19 on 10/6/20. -She was asymptomatic. -That was the last entry. -There was no documentation of her having had a physical assessment for Covid-19 before or after she was tested . *Her most recent blood pressure was obtained on 9/22/20. *Her temperature had not been monitored on 10/3, 10/4, 10/6, or 10/7. *The last oxygen saturation was obtained on 8/28/20 and was normal. *There was no documentation of a respiratory assessment. 12. Telephone call on 10/9/20 at 9:10 a.m. to DON A regarding lack of Covid-19 screening and assessments before or after [MEDICAL CONDITION] was identified revealed DON A confirmed it was her expectation that residents' screenings and assessments were to have been completed and documented in each residents' medical record. Telephone call on 10/13/20 at 2:20 p.m. with administrator B for Covid-19 assessment policies revealed the policy this writer had received must have been the wrong policy. The provider had a newer policy indicating the residents were to have been assessed only once daily. DON A was not available for another interview. 13. Review of the provider's undated Covid-19 Prevention and Control Guidance Policy and Procedure revealed: *It was established to implement controls to help prevent the spread of Covid-19. *All staff were to have their temperature taken upon arrival to the facility. *The provider was to have documented any signs of respiratory, gastrointestinal or Covid-19 symptoms. *All residents will be screened daily at a minimum for temp (temperature). COVID-19 symptoms may not be typical in LTC (long-term care) residents. Transmission precautions would be implemented. Physicians would be notified. *Any resident showing symptoms will be quarantine and vitals taken at least 3 times each day to assess for worsening condition.

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