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 _____	**04/23/2020**

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, phone interview, record review, policy review, and job description review, the provider failed to ensure a thorough investigation had been completed for one of one sampled resident (1) who had eloped. Findings include: 1. Review of information submitted to the South Dakota Department of Health (SD DOH) complaint department from an anonymous complainant regarding resident 1 revealed: *The incident had occured on 4/10/20. *He had been approached by three staff members outside of the building. -They were attempting to get him back inside. -He became very upset with the staff and was aggressive towards them. -The approach of the three staff members likely made him feel like he was cornered. -He was sat in a wheelchair (w/c) when brought back inside the buidling. -His agitation and agression continued. *A staff member was instructed by the nurse to sit on him in the w/c to keep him still while she contacted the physician. *He was given a medication injection of [MEDICATION NAME]. *He had never required a give as necessary (PRN) medication in the past, and they felt his behavior issues could have been managed wth a different approach. Review of the provider's final 4/14/20 SD DOH Online Self Reporting form for resident 1's 4/10/20 incident revealed: *The form had been completed by the social service designee (SSD). *Allegation type: Elopement. *Was abuse/neglect allegation substantiated was documented as no. *A brief explanation of the event was documented: -Was at the vestibule door and wanted to go outside. -Staff member was trying to convince resident that he could not go outside. -Resident pushed his way through the door. -Door alarm set off and recorder went to the door and tried to convince resident that it was not a good time to go outside. -Resident was pushing staff, hitting staff members to get outside. -When resident got outside he started to run. -Staff attempted to stop resident for his safety and he continued to push, kick and punch staff. -Recorder call overhead for assistance outside. -Staff finally got resident to sit in wheelchair and brought back inside. -Resident was very agitated and continued to swing at staff. -On call physician called and one time order of [MEDICATION NAME] 5 milligrams given at 1850 (6:50 p.m.). -Resident was quite a bit calmer at 1905 (7:05 p.m.). -Resident is resting in bed quietly. *The SSD conclusionary investigation revealed: -She had read through the incident report, documentation, and completed staff interviews. -His dementia had progressed. -He had been moved from assisted living to long term care status. -He had not comprehended why he could not come and go as he wished. -He did get very agitated in situations that he could not have full control over. -He was receiving behavioral services and medication management through (company name). -He had been started on an antidepressant medication and then changed to an antipyschotic medication. -They had discussed different alternatives for placement with the guardian and decided to have him remain in the facility. -His care plan was reviewed and updated. -Staff were to receive education on how to handle residents with Dementia/Alzheimer's and they will also receive coaching opportunities per Adminstration. -He was going to start receiving therapy services and continue with behavioral serivces. *The final report had not included: -How they had brought him back into the facility. -Any documentation of a nurse telling a staff member to sit on him. -Any staff member sitting on him as they brought him back into the facility. -A staff member had asked a nurse prior to his elopement that she had wanted to take him outside for a walk to calm him down. Observation on 4/22/20 at 9:45 a.m. as the surveyor's were entering the facility parking lot in their cars there was an older gentleman with a younger woman outside by the facility sign. Neither one had a face mask covering their mouth and nose. After the surveyor's exited their cars they were met by the younger woman who now had a face mask covering her mouth and nose and: *She identified herself as the activity director. *The older gentleman that had been with her was identified as resident 1. -He was now inside of the facility. Review of resident 1's medical record revealed: *The 2/12/20 quarterly Minimum Data Set (MDS) assessment had been coded as: -The Brief Interview for Mental Status examination score was thirteen indicating he was cognitive. -He had a [DIAGNOSES REDACTED]. -His current behavior status, care rejection, or wandering had been coded as improved compared to the prior MDS assessment. -He was independent in walking on and off the unit. -He was steady at all times without any functional limitation in his range of motion. -He did not require any mobility devices. -He was occasionally incontinent of bladder and always continent of bowel. -He was not receiving any medication for pain. -He had not had any falls. -He was not any [MEDICAL CONDITION] medications. -He was not receiving any therapy services. -He had not had any restraints used on him. Review of resident 1's behavior monitor flow sheets documentation from 3/26/20 through 4/22/20 revealed: *He had wandered nine out of twenty-eight days. *He had rejected care one out of twenty-eight days. *He had kicked or been hitting one out of twenty-eight days. *There was no documentation he had made attemps to leave the building or was exit seeking. *There were no behaviors documented on 4/10/20 the day of the incident. -It had been documented nothing had been observed at 10:10 a.m. and at 8:28 p.m. Review of the nursing progress notes from 3/26/20 through 4/22/20 regarding resident 1 revealed on the following: *4/2/20 at 2:38 p.m.: Tele med conference with (pyschiatrist name and behavioral health therapist name). *4/5/20 at 9:52 a.m.: He had moved his bed in front of his door. Hard to redirect. Trying to put his legs in sleeves of his jacket. *4/7/20 at 9:00 a.m.: Very restless this AM. Early AM he had gotten outside. -He had been heading to the church across the street. -Three staff went to get him to come back and he resisted all the way. -He was in a w/c and they had to have the front wheels up in order to get him back. He kept putting his feet down. --The previous documentation had been two days before that. --There was no documentation if the w/c had foot pedals on it or how they had gotten him into the w/c. *4/7/20 at 5:10 p.m.: Activities had an extra person come in to supervise (resident name) while he was outside planting. *4/10/20 at 6:50 p.m.: a medication administration note for [MEDICATION NAME] 5 milligram/milliliter (mg/ml) intramuscularly one time only for agitation. -There was no mention of why that [MEDICATION NAME] was given or what was occurring at that time. -There were no notes regarding the resident's status following the administration of the [MEDICATION NAME]. *4/10/20 at 7:40 p.m. There was a progress note from activity director H who had called the facility and had been told about resident 1's elopement. She had not been in the facility at the time of the event. *4/12/20 at 9:53 p.m.: He had gone out the west door. Staff redirected him back inside. Very agitated tonite. *4/13/20 at 1:20 p.m.: Attempted to go outside. Staff able to redirect resident. Review of the 4/10/20 Elopement report by registered nurse (RN) F revealed: *On 4/10/20 at 7:50 p.m.: Resident was persistent on going outside. When tried to redirect resident back in side (sic) he became physically aggressive. Resident was swinging, pinching, punching staff. Staff tried redirecting resident back inside due to safety issue. Resident was still resistive. Staff was able to get resident to sit in his wheelchair and staff brought resident back into facility. Witnesses (CNA E and I, dietary aide D, and RN F). *Immediate action taken was: On call physician, (certified nursing practitioner (CNP) C) notified. One time order for [MEDICATION NAME] given at 1850 (6:50 p.m.) and resident was much calmer at 1910 (7:10 p.m.). Resident is not (now) resting quietyly in bed. *There was no documentation: -How he was assisted into the wheelchair. -Regarding a staff person sitting on him or being told by the nurse to sit on him. *The information listed on this report was not listed in his medical record. Review of the following physicians' progress notes for resident 1 revealed on: *2/6/20: Seems slightly more confused. Alert oriented to person, place, and time. *3/20/20: Oriented to self and place.

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

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Pleasant and cooperative. Enjoys gardenting in the spring. Pain management Tylenol if needed. Review of the following physicians' faxes for resident 1 revealed on: *4/2/20: Per psychiatrist [MEDICATION NAME] 15 mg at HS (hour of sleep). -Primary phsycican gave consent. *4/7/20: Extremely restless trying to runaway. (Pyschiatrists name) recommends to stop [MEDICATION NAME] 15 mg at HS and start [MEDICATION NAME] 12.5 mg at HS. -Primary physician gave consent. *4/14/20: Order for occupational therapy to evaluate and treat. *4/19/20: Resident eloped from building but was escorted back in with no injury. State report done and family notified. -Physician acknowledged fax on 4/20/20. Review of resident 1's current care plan revealed it had been updated on 4/13/20 and 4/14/20 for interventions for elopement. Review of the 4/2/20 treatment summary by (pyschiatrist name) regarding resident 1 revealed: *He has had evidence of progressive cognitive decline consistent with dementia. *Recently, he has been exhibiting increase symptoms of anxiety and irritability. *He has been more agitated and difficult to redirect. *He tends to enjoy spending time outside and has been more anxious and irritabble when not being able to go outside. *Psychiatrist ordered [MEDICATION NAME] to be given at bedtime. Review of the 4/7/20 physician's progress note from (pyschiatrist name) regarding resident 1 revealed: *Telephone call from nursing home. Patient (resident) extremely agitated and difficult to redirect. -He has eloped from facility several times and did put his bed against the door. -Attempting to put is jacket on his legs. Review of the psychiatric consultant social worker reports regarding resident 1 on the following dates revealed: *3/10/20: -He is pleasant today. - He continue to progress with his dementia which has caused agitation. -Have scheduled him for an appointment with (psychicatrist name) for medication recommendation. -Expected treatment outcome is less agiation assosicated with his dementia. -Prognosis is guarded. *4/2/20: -He indicates that he was able to go outside yesterday and thoroughly enjoyed this. -He is pleasant today. -He continues to have good and bad days as far as agitation is concerned. -Prognosis is fair to good. *4/21/20: -Staff did state that he continues to try to elope at times but they have worked with him to return to the facility with various approaches. -He is pleasant but dementia progresses. -Prognosis is guarded. Interview on 4/22/20 from 10:00 a.m. through 10:40 a.m. with CNP C regarding resident 1 revealed: *She alternated visits with (physician name) at the facility. *She was well aware of resident 1. *She had been surprised when the nurse had called her on 4/10/20 regarding the resident's elopement and behavior. *He had cognitive deficits. *He had started to have sundowning. -That was a new behavior. -He had become more aggressive. *She was not aware of any of the behaviors prior to the 4/10/20 incident. *He had tried to leave the building due to being in lockdown from the [MEDICAL CONDITION]. -He was more forgetful and his independence had declined. -He had started new behaviors such as disrobing and going into other residents' rooms. *She confirmed the 3/20/20 was the most recent physician note. *The urine analysis after his elopement had been negative. *They had done lab work in February 2020. -It had been within normal limits with a little sign of dehydration. -He had no acute illness at the time of the elopement. *She had gotten a call from RN F regarding the elopement on 4/10/20. -She had been working in the emergency department (ED) of a hospital. -RN F had informed her he was hitting, pulling their hair, and they could not get him to calm down or reason. -She could hear resident 1 yelling from outside of the buidling over the telephone while talking with RN F. -She reviewed what medications were in the emergency kit box. -She decided to order a one time dose of [MEDICATION NAME]. --She felt [MEDICATION NAME] was faster acting and more appropriate for his behaviors instead of [MEDICATION NAME]. --She felt [MEDICATION NAME] worked better to stop a dementia psychotic break and dementia behavior. *He had started to show more signs and symptoms of behaviors. -They had made some medication changes. *She had been trying to get the nurses to put more documentation into their electronic medical record (EMR). -She had wanted them to keep notes from physician visits, so she had those as a reference during visits. *She thought the nurse should have completed better documentation for the 4/10/20 incident. -The activity coordinator (AC) should not have been the one to document about the incident in the EMR. --It was the nurse's responsibility. *She agreed more documentation from the nurses on what resident 1's behaviors had been prior to the 4/10/20 event should have been documented. -There was no documentation by the nurse after the [MEDICATION NAME] had been given to him -She would have expected that to have been done. -She had expected resident 1 might have been sent to the ED following the 4/10/20 incident. *She was not sure of a memory care unit for him. -He was going to have a follow-up appointment with the psychiatrist. *Due to the COVID-19 restrictions they were making attempts to get back to a more personalized activity program for him. *Her further expectations regarding nursing documentation for resident 1 would have been for the nurse to document what and how the resident was doing after the [MEDICATION NAME] had been administered, to have documented vital signs, and to have been monitoring him for any changes. *She knew they needed to work on their documentation. *When asked about a staff member sitting on his lap she felt that would have been inappropriate. Interview on 4/22/20 from 11:00 a.m. through 11:27 a.m. with dietary aide (DA) D regarding resident 1 revealed: *She had worked a thirteen hour shift on 4/10/20. *She had observed he had wanted to go outside. -He had asked her if he could go outside, and she told him to go ask a nurse. *She was in the process of letting another staff member into the building by the door closest to the dumpster when: -She overheard RN F tell another staff member she had tried everything to redirect him. *He had gone to another door. *He pushed her out the door by the main entrance door. -She felt he was on a mission to get to his garden. *He got to the edge of the sidewalk then wanted to get a bus. *RN F had called the other staff on the radio to come and assist with him. *He had gotten to the edge of the parking lot by the grass and was swinging his arms at the nurse while she was trying to redirect him. *It seemed he was angry at the nurse. *At that time CNAs E and I had joined them outside. *He continued swinging and hitting at her. *Another dietary person had brought a w/c out to where they were. *Another staff member was holding the door open. -They brought him in the dining room door. -When he went into the w/c he had a hold of both her arms, and he pulled her into the w/c with him. -RN F had told her to sit on him in the w/c. -He was choking her. -They wheeled him into the nursing home. -He had her head in a head lock and a hold of her neck. -Her knees were between his legs. -She was not physically sitting on him. -She felt she had not sat on him. -The only physical contact he had with her was when he pulled her into the w/c. *Once in the dining room he was angry. -She walked him to his room, he started to calm down, he then saw the nurse, and began to swing at her. -Once in his room CNA M tried to stop him from swinging at anyone. -She left the room. -She knew he had gotten a shot. -She had been instructed not to leave the building as she had to write down an account of what had just happened. *On her next scheduled shift which was a day or two later her supervisor, the certified dietary manager, asked her what had happened. *She had been questioned by the administrator on the incident. -The administrator had spoken to her on how things should have progressed. *They had meetings every month on how to deal with residents with behaviors. -She had worked at the facility since August 2019. -During general orientation they had reviewed abuse and neglect. *Resident 1 had not had any other days prior to the incident where he had displayed those behaviors. *She felt his cognition had changed since last August. *She speculated if they had let him go outside for awhile the incident could have been prevented from escalating. *With COVID-19 he could not go outside like he used to, and he needed to be supervised when out. -He liked to garden. *She felt RN F had remained calm during the entire incident. Interview on 4/22/20 at 12:05 p.m. with CNA E regarding resident 1 revealed: *She strictly worked the evening shift. -Usually from 2:00 p.m. through 10:30 p.m. *She had been in a resident room when she heard RN F calling over the intrercom system they needed assistance by the vestibule/main entrance by the patio for help. *When she went out side she saw DA D and RN F with the resident. -He had been running from DA D and RN F. -He had been hitting at them. *The nurse told DA D they were good, and she could leave. *She felt DA D was persistent and continued to hold onto him. *It took ten to fifteen minutes to get him back into the building. *Another CNA went back into the building to get a w/c. *He continued to hit and kick at the staff members. *DA D had been sitting on him in the w/c facing forward when they brought him through the door. *She felt DA D decided herself to hold onto him and then sat on him. *No one told her to sit on him. -She did it on her own. *Everyone was trying to get him inside. *They pushed him forward in the w/c. *They brought him back into the building through a different doorway. *He continued hitting everyone and had tried to choke DA D as she sat on him. *Once inside the building DA D got off of him. *They brought him to his room. *RN F gave him a shot, he calmed down, and then went to bed. *CNA M stayed with him until he calmed down and went to bed. -He had hit CNA M a few times. *DA D had been told not to sit on him, but she sat on him prior to bringing him back into the building. *RN F had called the CNP from outside of the building. -He had gotten a shot to calm him down when he was back in his room. *DA D had come with them to his room. -DA D had left the room after he had gotten his shot. *She had been asked to fill out a form regarding injuries and incidents. *She later made a statement to RN F for the state report. *The director of nursing (DON) came to the facility after the incident and talked to her. -The DON told her to watch him and keep him safe. *Following the incident the activity director had told them they needed to wait until different approaches were done since he had been so worked up. *She felt DA D had been persistent with trying to get him back into the building. *Prior to the 4/10/20 incident he had no major outbursts. -He was getting cabin fever. -Due [MEDICAL CONDITION] he had not gone outside as much. *She knew prior to her shift he had tried to go outside a few times and was looking for the bus station. -From 2:00 p.m. until 6:45 p.m. he

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) was doing his own thing by walking around inside of the building. -In the past they had tried to make time to take him outside. -He had bad sundowners and could be difficult to redirect. -The activity department usually took him outside during the day and would go for walks with him. *He had been okay since the incident. -They had placed signs on the exit dos to redirect him and other residents with dementia. *She had received training on abuse and neglect, reportable incidents, and behaviors. *They had put out more education related to residents with behaviors, Alzheimer's, and approaches since the 4/10/20 incident with him. -There was a board in the breakroom with the above information on it. Telephone interview on 4/22/20 from 12:35 p.m. through 1:07 p.m. with RN F regarding resident 1 revealed: *She: -Worked the 5:45 p.m. through 6:00 a.m. shift. -Had been employed for three months. *On 4/10/20 resident 1: -Had gone out the front door. -The door alarm had sounded. -He was agitated, hitting, pinching, and choking the staff. -Four staff had attempted to get him inside. -She did not want him to get hurt. -He had been more agitated than usual and was pushing staff members. -That behavior had started around 7:30 p.m. to 8:00 p.m. --That had not matched with the documentation. -He had been exit seeking and wanting to leave the building. -He had been agitated since she had come on duty. -She had tried to redirect him by talking about sermons. -No one had tried to take him outside for a walk. -That was the first time he had eloped for her. -He had been more confused on 4/10/20. -He went out the dining room door, the alarm went off, DA D had seen him exit the building. -When the alarm went off she had been in another resident's room doing a treatment. -She went right away to see about the alarm. -He had pushed his way past the kitchen gal and she had gone out after him. -He kept walking on the sidewalk, and when he got to the end of the building she ran back in to call for back-up assistance. --She had called over the intercom system. -She had left DA D outside with him. -When she went back outside he was pushing, hitting, and yelling at DA D. -Someone brought a w/c outside, and they then brought him back into the building. -He had been assisted into the w/c by DA D, CNAs E and I, and herself. *They tried talking to him, but he kept arguing with them. -He was hitting at them. -It happened so fast. -They had wheeled him in the w/c into the building facing forward. --CNA I was on his side. --She was in the back. --Another CNA was in the front. --CNA E and DA D were standing to his side. --No one had to hold him in the w/c to keep him from getting up. *They took him to his room. -CNA M had stayed with him. *She had gotten a prn [MEDICATION NAME] order for him. -CNA M stayed in his room and had one-to-one interventions with him. -She called the physician after they had gotten him back inside. -She gave his medication injection to him in his room. --She had staff members distract him while she rolled up his sleeve and administered the medication. *No one had asked her if they should take him for a walk prior to that event. -He settled down and was calm the rest of the evening. *She had checked on him periodically to ensure he was okay. -He was not comprehending anything. *She thought she had documented in the progess notes. -The event note had been completed under risk assessment, fall note, and state report. -She was not sure if the reports were part of the EMR. -It should have been under risk assessment and elopement. *The DON: -Came over to the nursing home to help her complete the reports since she had not done a state report. -Talked to her about paper work and what could have been done different with the incident. *She could not remember anyone sitting on him during the incident. *She had not instructed anyone to sit on him. -It happened so fast. *She felt it would have been inappropriate for someone to have sat on him. -Looking back she felt there were too many people involved. --It had aggravated him. -Her main goal was for his safety. -Can't go back and change anything. *If she had to do it all over again she would have had someone walk with him. -He had been very agitated that day and did not consider it his normal agitation. -She should have made a note in the incident report he had refused his vital signs to have been taken. *When she called the provider she told her he had been more agitatied. *She had not been aware of him being on [MEDICATION NAME] or [MEDICATION NAME]. -The medication aide gave the medications. -She had completed the initial twenty-four report for the SD DOH. --Someone had completed the final report. *Following the incident the administrator had called her and visited with her regarding helpful hints on how to redirect him. *They had just had an in-service on dementia following the above incident. -They had touched on residents with unique needs and abuse and neglect. Interview on 4/22/20 from 1:15 p.m. through 1:30 p.m. with SSD G regarding resident 1 revealed: *She had a social work consultant. -She had never visited with her about resident 1. -They usually visited about other situations. *She felt his dementia had been progressing. *He was followed by a behavioral services, pyschiatric social worker (SW), and psychiatrist. -The SW had seen him for over a year. -The psychiatrist had just been added due to his increase in agitation. -They had ordered [MEDICATION NAME] for his [MEDICAL CONDITION]. -He had been up a lot at night and would wander into other residents' rooms. -They wanted him to rest better. -After one week he made attempts to elope. -The day of the elopement they thought the [MEDICATION NAME] was having adverse effects -They had contacted the psychiatrist, the [MEDICATION NAME] was discontinued, and a new order for [MEDICATION NAME] had been given. -The team had discussions on what would be the best placement for him. -They had discussed a memory care unit. -She had contacted two different facilities. -She had four conversations with the resident's daughter, and they felt a change would be difficult for him. --The Covid-19 had been very traumatic for him due to social distancing and confinement. -They were going to give it a month and re-evaluate how he was doing. *They did not have flow sheets for tracking resident behaviors. *They usually charted the negative behaviors in the EMR. -She had found the behavior flow sheets within their EMR system and felt that was something they could begin to use. *She did not feel the 4/10/20 incident and follow-up had been handled appropriately. -She had gotten a call at home related to the incident. -She had been told the administrator had visited with RN F about the incident. -She had gone over the elopement policy and procedure with RN F following the incident. -She had been told a staff member had sat on him during the above incident. *She had completed the five day investigation report that was submitted to the SD DOH. *The administrator had not completed any documentation except for his conversation with RN F. *The investigation had been done by the administrator, DON, and herself. -She had completed the final report. -The incident report was not part of the EMR. *She had heard second hand that RN F told the DON, who told her, that DA D had sat on him during the incident. -If DA D had sat on him during the incident she would have considered it a form of abuse. *She had felt he was not a threat to other residents or staff and had no indications of physical or sexual intentions toward other residents. *She confirmed the documentation had not supported a thorough investigation had been completed to rule out abuse and neglect. -The DON and administrator had done the staff interviews, but they had not documented those. -She had not really participated in the investigation but had completed the five day report to the SD DOH. Interview on 4/22/20 from 1:50 p.m. through 2:10 p.m. with AC H regarding resident 1 revealed: *She had worked at the facility for almost two years. *The resident has had behaviors in the past. *Last summer he had a vergal disagreement with another resident but nothing physicial had happened. *Lately he had been exit seeking and wanting to go outside more since it was nicer weather. *She felt he was not exit seeking when the 4/10/20 incident had occurred. *On 4/10/20 she had called the facility around 7:00 p.m. to talk to CNA M who also worked in the activities department. -She was not in the building at that time. -RN F had answered the phone and told her the resident had gotten outside and was having behaviors towards the staff. *RN F told her resident 1 had punched her in the chest and stomach and had choked another staff member. *She then called CNA M who was in resident 1's room. -CNA M put his phone on speaker phone, so resident 1 could talk to her. -He wanted to talk to his daughter. -He had de-escalated at that time and was calmer. *She called his daughter and told her a little bit about the incident. -She asked the daughter to call him. *She had not come into the building. *She called the administrator and asked him to check into the incident. *DA D told her RN F had told her to sit on him during the incident, so she did. *The dietary manager told her RN F had told DA D to sit on him. *She had visited with the administrator and told him they needed extra training on dementia and behaviors. *The administrator said he would talk to everyone/coach them, so it would not happen again. *She had not seen the dementia training hand out from the administrator. *Medication aide (MA) N had told her she had spoken to RN F and had offered to take him outside for a walk due to his restlessness prior to the incident. -RN F had told MA N no. *She was not at the facility on 4/10/20 when the incident had occured. *She was not part of the investigation team. Interview on 4/22/20 from 2:10 p.m. through 2:25 p.m. with CNA I regarding resident 1 revealed: *She had worked at the facility for nineteen years in different departments. *She usually worked the evening shift. *She was the last one on the scene of the above incident. *When she got there it was resident 1, RN F, and CNAs E and M. *They were facing the parking lot. -He was trying to get away. -He was pushing everyone out of the way. -She had tried to talk to him. *She had not heard or seen anyone tell DA D to sit on him. *She felt DA D had been persistent with trying to get him to go inside the building. *She did not see anything. *She was holding the door as they brought him into the building but was not looking at who was doing what. *The DON had come that evening and asked what had happened. *She had never seen resident 1 act like that. -He was more confused and had been doing odd things such as thinking day time was evening. *The night after the incident he had gone to the fenced in area and was redirected easily back into the building. *They had gotten a packet on dementia and elopement training. -They had to take a test when they were done reading it. Interview on 4/22/20 at 2:40 p.m. with DON B regarding resident 1 revealed: *She had been the DON at the facility for eight years. *She had received a

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	435088	A. BUILDING _____ B. WING _____	04/23/2020

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

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) text message after the incident on 4/10/20 was over. *When she got to the nursing home he was laying in his bed. *She talked to MA N. -She did not know why RN F had said no to MA N when she wanted to walk with him outside prior to the incident. *She had visited with the rest of the staff who were involved in the incident. -DA D had been trying to get him to come into the building. *She agreed they had to physically sit him into the w/c. *They should have walked him in to the building and not used the w/c. -RN F should have known to do that. *On Monday morning (4/13/20) when she looked at the EMR she saw there was no follow-up documentation on the incident. -RN F had thought since she filled out the incident report that was good enough. *She felt the situation was not handled well. *She had done verbal coaching with the three CNAs and the dietary aide following the incident but had not documented it. -There was nothing in their personal files regarding the above. *The incident report was not part of the medical record. *She agreed there had not been much on documentation for resident 1 regarding the 4/10/20 incident, his change in behaviors, the new medications, and follow-up to everything. *She had been informed by RN F that DA D had fallen on him while getting him into the w/c. *All of the staff were given a packet of information consisting of dementia, elopement, and behaviors from the administrator. -They were to read it and then turn the signed sheet back into her. -There was no date given when the above was supposed to
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure one of one sampled resident (1) who had dementia and behaviors had received appropriate interventions and documentation to support his psychosocial well being prior to, during, and after an elopement. Findings include: 1. Review of information submitted to the South Dakota Department of Health (SD DOH) complaint department from an anonymous complainant regarding resident 1 revealed: *The incident had occured on 4/10/20. *He had been approached by three staff members outside of the building. -They were attempting to get him back inside. -He became very upset with the staff and was aggressive towards them. -The approach of the three staff members likely made him feel like he was cornered. -He was sat in a wheelchair (w/c) when brought back inside the buidling. -His agitation and agression continued. *A staff member was instructed by the nurse to sit on him in the w/c to keep him still while she contacted the physician. *He was given a medication injection of [MEDICATION NAME]. *He had never required a given as necessary (prn) medication in the past, and they felt his behavior issues could have been managed wth a different approach. Review of the provider's final 4/14/20 SD DOH Online Self Reporting form for resident 1's 4/10/20 incident revealed: *The form had been completed by the social service designee (SSD). *Allegation type: Elopement. *Was abuse/neglect allegation substantiated was documented as no. *A brief explanation of the event was documented: -Was at the vestibule door and wanted to go outside. -Staff member was trying to convince resident that he could not go outside. -Resident pushed his way through the door. -Door alarm set off and recorder went to the door and tried to convince resident that it was not a good time to go outside. -Resident was pushing staff, hitting staff members to get outside. -When resident got outside he started to run. -Staff attempted to stop resident for his safety and he continued to push, kick and punch staff. -Recorder call overhead for assistance outside. -Staff finally got resident to sit in wheelchair and brought back inside. -Resident was very agitated and continued to swing at staff. -On call physician called and one time order of [MEDICATION NAME] 5 milligrams given at 1850 (6:50 p.m.). -Resident was quite a bit calmer at 1905 (7:05 p.m.). -Resident is resting in bed quietly. *The SSD conclusionary investigation revealed: -She had read through the incident report, documentation, and completed staff interviews. -His dementia had progressed. -He had been moved from assisted living to long term care status. -He had not comprehended why he could not come and go as he wished. -He did get very agitated in situations that he could not have full control over. -He was recieving behavioral services and medication management through (company name). -He had been started on an antidepressant medication and then changed to an antipyschotic medication. -They had discussed different alternatives for placement with the guardian and decided to have him remain in the facility. -His care plan was reviewed and updated. -Staff were to receive education on how to handle residents with Dementia/Alzheimer's and they will also receive coaching opportunities per Adminstration. -He was going to start receiving therapy services and continue with behavioral serivces. *The final report had not included: -How they had brought him back into the facility. -Any documentation of a nurse telling a staff member to sit on him. -Any staff member sitting on him as they brought him back into the facility. -A staff member had asked a nurse prior to his elopement that she had wanted to take him outside for a walk to calm him down. Observation on 4/22/20 at 9:45 a.m. as the surveyor's were entering the facility parking lot in their cars there was an older gentleman with a younger woman outside by the facility sign. Neither one had a face mask covering their mouth and nose. After the surveyor's exited their cars they were met by the younger woman who now had a face mask covering her mouth and nose. *She identified herself as the activity director. *The older gentleman that had been with her was identified as resident 1. -He was now inside of the facility. Review of resident 1's medical record revealed: *The 2/12/20 quarterly Minimum Data Set (MDS) assessment had been coded as: -The Brief Interview for Mental Status examination score was thirteen indicating he was cognitive. -He had a [DIAGNOSES REDACTED]. -His current behavior status, care rejection, or wandering had been coded as improved compared to the prior assessment. -He was independent in walking on and off the unit. -He was steady at all times without any functional limitation to his range of motion. -He did not require any mobility devices. -He was occasionally incontinent of bladder and always continent of bowel. -He was not receiving any medication for pain. -He had not had any falls. -He was not any any [MEDICAL CONDITION] medications. -He was not receiving any therapy services. -He had not used any restraints. Observation, interviews, and record review throughout the survey on 4/22/20 from 9:45 a.m. through 4:15 p.m. and off-site on 4/23/20 revealed concerns with the provider's dementia care and services for resident 1. Refer to F610, finding 1.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, phone interview, record review, and policy review, the provider failed to ensure one of one sampled resident (1) had complete documentation in his medical record related to an elopement. Findings include: 1. Review of resident 1's medical record revealed incomplete or missing documentation related to an incident that occured on 4/10/20 and the details surrounding it including: *Documentation in the medical record by the registered nurse F regarding the incident. *The resident's behaviors prior to, during, and after the incident. *Follow-up for the use of a one time order for the medication [MEDICATION NAME]. Refer to F610, finding 1.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, phone interview, record review, and policy review, the provider failed to ensure a comprehensive infection control plan and process had been implemented for the current COVID-19 pandemic related to: *Multiple staff (dietary aide D; certified nursing assistants (CNA) E, I and L; social services designee (SSD) G; activity coordinator H; and registered nurse (RN) K) had been observed not wearing their face coverings properly. *Surveyors were not screened appropriately upon entering the facility. *Lack of staff knowledge regarding the current reporting guidelines and process for COVID-19 to the South Dakota Department of Health (SD DOH). *Lack of documentation to support monitoring of residents and staff for symptoms and testing that had been done for COVID-19. *Infection control policies appeared unfinished and not comprehensive or specific to COVID-19. *There had only been one documented staff infection control training done recently on 3/19/20. -That training appeared generalized and not specific to COVID-19, and some staff members had not completed it. *There had been no process to ensure staff were competent and following infection control practices related to COVID-19. Findings include: 1. On 4/22/20 at 9:45 a.m. as the surveyor's were entering the facility parking lot

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) in their cars there was an older gentleman with a younger woman outside by the facility sign. Neither one had a face mask covering their mouth and nose. After the surveyor's exited their cars they were met by the younger woman who now had a face mask on covering her mouth and nose. *She identified herself as the activity director. *The older gentleman that had been with her was identified as resident 1. -He was now inside the facility. *She had walked with the surveyors to the locked door and called for another staff member to let us in. *SSD G let us in and assisted with the screening process for visitors. -She checked both surveyors temperatures and wrote our names, temperature, and the time on a log sheet. -She had not asked any further questions about symptoms, travel, or exposure related to COVID-19. *The log sheet of visitors/staff names was on a bedside table near the doorway that also held a container of hand sanitizer. *SSD G indicated all staff had to have their temperature taken prior to starting their shift, and that was documented on the log sheet. *Staff and visitors had been doing a questionnaire form each time they entered the facility. *The questionnaire asked them about symptoms and travel along with the temperature checks, but that had been stopped a few days ago. -She was unsure why that questionnaire had stopped, but all staff knew they should not come to work when they were not feeling well or had symptoms. *The surveyors then entered the facility and met with the administrator. *Random staff in the hallways and at the nursing station were wearing handmade cloth face coverings. Entrance conference with administrator A immediately after entering the facility revealed:*Surveyors explained the purpose of the survey and the need to conduct a COVID-19 focused infection control survey along with the complaint survey. *He was given the entrance conference form and the focused survey form. -Al items related to the focused survey were requested at that time including policies and training related to COVID-19. *He indicated RN J was their infection control nurse. -She was not working that day due to a family member being tested for COVID-19. *Director of nursing (DON) B was in the facility and also assisted with the infection control program. *General questions related to COVID-19 were asked and the responses included: -All staff were being screened prior to their entry to the facility by a different staff person. --That should have included questions about any symptoms along with their temperature checks. --The surveyors should have been asked about any symptoms or exposure to COVID-19. -Staff had been wearing the handmade cloth face coverings for about two weeks already. -If they had a suspected or positive COVID-19 resident they would have isolated them to their room or moved them to a private room. -If there was more than one suspected or positive COVID-19 resident they would cohort residents at that time. --There was no specific written plan for that. -If COVID-19 testing for residents was needed they would have had staff from a clinic in a nearby town come to the facility to perform the collection and testing. -They had a few staff that had already been tested for COVID-19. --Those staff had negative tests. Interviews and observations on 4/22/20 from 9:45 a.m. through 4:00 p.m. revealed: *Staff were wearing handmade cloth face coverings. *Multiple staff were seen throughout the facility and nearby residents: -Adjusting the cloth face coverings and touching them frequently. -Putting the cloth face coverings below their chin. -Having the cloth face coverings only cover their mouth and not their nose. --Those staff included: dietary aide D; CNAs E, I and L; SSD G; activity coordinator H; and RN K. *Some of those face coverings had ties to hold them on and some had elastic. -Several appeared to not fit properly or stay in place well. At the time the surveyors exited on 4/22/20 at 4:15 p.m. they had discussed with administrator A the need to continue the off-site review the following day. They had requested him to send them the remaining focused survey items electronically which included policies and evidence of staff training related to COVID-19. Those items were received by email on 4/23/20 and included: *A revised March 2020 Infection Control policy that indicated it should have had four pages. -Six pages were received. -The third page appeared out of place and was only half full. -The fourth page was labeled as page three of four. -The fifth page appeared out of place and had two very short paragraphs at the top of the page. -The sixth page was labeled as page four of four. -The numbering/lettering for the labeling the sections appeared to be missing items. --Pages one and two had sections A through G. --Page three had section H. --Page four had section L. ---There was no sections labeled I or J. --Pages five and six had no letter labeled sections. -There was only one small section on page four that mentioned COVID-19 and it stated:--COVID-19: Place the resident in a private room once they are showing possible symptoms. Once a confirmed positive must be quarantined from the rest of the resident population. Maybe (may be) only be with another resident if that resident still has an active confirmed COVID case. Staff will be given correct PPE (personal protective equipment) to provide the resident cares. Will only have certain staff members dedicated only to caring for those residents. Resident maybe (may be) released from Quarantine only once is negative. Negative is determined either by 2 negative test 24 hours apart from each other. Also negative 3 days after symptoms subside or 7 days after the onset of symptoms whichever is later. -There was no mention of: --The process for monitoring the residents for symptoms prior to or during their illness or the documentation of that. --Tracking and trending of potential/actual cases of COVID-19 for residents or staff. --The reporting process to the SD DOH or who was responsible for that. --What source(s) were used to develop this policy, if any. *The infection control inservice, missed inservice, and trivia quiz were not dated as to when they were created or given to the staff. -They had been created by RN/infection control nurse J. -There was no documentation to support where she got the information from such as the source. -It had not mentioned COVID-19 specifically or how the general infection control information related to that. -Several times it mentioned See guidelines for Isolation Precautions, but those were not attached. *The 3/19/20 infection control staff sign-in sheet included thirty employee signatures. *The undated/unlabeled list of staff who had missed the above inservice had included thirty-three total names. -Fourteen staff had check marks indicating they had completed the training. -Three staff had nothing listed by their name. -Ten staff had PRN (as needed) listed by their name. -Three staff listed with no longer works here. -Two staff out on leave. -One staff who had not been there. *Review of the revised 3/19/20 employee phone list included seventy total staff names. -According to the sign-in sheet and missed inservice list only forty-four staff had completed the recent infection control training. Phone interview and record review on 4/23/20 from 12:50 p.m. through 1:25 p.m. with RN/infection control nurse J revealed:*She had been working at the facility since December 2019. *She completed her infection preventionist training in March 2020. *She also worked on residents' Minimum Data Set assessments and as a charge nurse at times too. *For the infection control portion of her duties she thought she spent about one to two hours a week on that. -Usually that was spent reviewing documentation and antibiotic use. *Specifically for COVID-19 preparedness and processes: -The facility had been closed to visitors for several weeks already, but she was unsure of the exact date. -There had been signs at the entrances explaining no visitors, and the doors were locked. -All staff and visitors including the surveyors should have been screened prior to entering the facility. -The screening should have included checking their temperature, asking about symptoms, and questioning about recent travel or exposure to COVID-19. --They had been using a questionnaire form with all those questions until recently. --They had stopped using that questionnaire but had continued checking temperatures and writing that on the log. -The questionnaire had been stopped, because it had been the same staff coming and going so frequently, and they were aware of what they should have reported. -All staff should have been aware not to come to work if they had any symptoms. -They were checking all residents' temperatures daily and documenting those. --No other symptoms were being documented as having been monitored related to COVID-19. -If a resident had a temperature of 100.4 degrees Fahrenheit or greater they would have put them into an isolation room. --Those residents would not have been monitored any differently than doing the daily temperature checks. --Staff assigned to residents in isolation rooms were the same staff assigned to other residents who were not in an isolation room. -Currently no residents had symptoms that would have indicated COVID-19 but if there were they would have designated specific staff to them at that time. -Staff were wearing handmade cloth face coverings and not healthcare specific masks. --She was unsure why they were using handmade face covering versus healthcare specific masks. --She was unsure what the facility's current supply of healthcare masks was or if they were running low. --The DON ordered medical supplies and monitored the amounts of them. -They had been using healthcare masks for residents if they needed to go out of the facility for anything. *Staff should have been wearing the cloth face coverings appropriately to cover their mouth and nose and should not have touched them frequently. -The face coverings should have been worn anytime they were in the facility and in the presence of residents or other staff. *Her usual process for tracking and trending of infections was done every month, and she monitored antibiotic usage. -She had not been tracking/trending the resident temperatures that were being done or monitoring specific for COVID-19 symptoms. *She had not done any specific employee tracking/trending related specific to COVID-19 other than the screening logs used when they came to work. -She thought there had only been one staff member that had been tested for COVID-19, and that test had been negative. --She was not aware of any others as indicated by the administrator's interview on 4/22/20. *She did not think there was any sort of written plan specific to cohorting of residents either suspected or positive for COVID-19. -They had talked about using the therapy room though. *She confirmed the infection control policies were not comprehensive or specific for COVID-19 other than a short paragraph. -The policies appeared incomplete. *There had only been one documented education session given to employees on 3/19/20.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) -Not all the staff had been there in-person for the training. -She had tried to give the education to the others as she was able, but some employees had not completed that training yet. *She confirmed the infection control materials used during that training had not been dated, had not indicated where the information had come from such as a relevant source, and had not listed COVID-19 specific information to be aware of. -She stated she had pulled the information from the Centers for Disease Control (CDC) website, but she had not listed that as the source. *She was unsure of the process for reporting diseases to the SD DOH or the guidelines for reporting suspected or positive COVID-19 residents or staff. -Reporting of communicable diseases was something she had heard of in the past, but she had not had to do that yet. *When asked the guidelines related to COVID-19 and how that education would be given to the staff since the guidance was changing frequently she indicated: -Administrator A had been part of the webinars and updates coming out, and he would tell them about the changes. -Administrator A, DON B, and the other department heads got the information out to their departments. *There was no specific process for ensuring all staff received information. -Sometimes it was meetings, text communication, during report between shifts, posters in the breakroom, or other methods. *Staff had started wearing cloth face coverings a few weeks ago, but she was unsure of the exact date. --She thought the DON and administrator had let all the staff know about that change, but she was unsure how. *She confirmed there was no documentation to support the changes and education and training to the staff other than the one training on 3/19/20. *There was no auditing or monitoring process to ensure the staff were using appropriate infection control practices related to COVID-19. -If she saw someone doing something incorrectly she would have given them verbal education. --There was no documentation to support audits or monitoring was being done. *She agreed there were things they could have been doing differently to ensure appropriate preparedness for the COVID-19 pandemic. Phone interview and record review on 4/23/20 from 2:00 p.m. through 2:30 p.m. with DON B revealed: *She confirmed staff should have been wearing the cloth face coverings appropriately. -They should have covered their nose and mouth and not have been touched or adjusted frequently without proper hand hygiene. *They had been wearing the handmade cloth face coverings to conserve their healthcare masks, because they did not have many of those. -They had tried ordering them from their usual vendors but had been unable to get them. -She was not aware of the state stockpile supply of personal protective equipment that could have been requested. --She thought administrator A might have known about that. *She was unsure about a plan for cohorting suspected or positive COVID-19 residents. -She had heard of using her office or the business office if needed. *She was unsure of the process for reporting suspected or positive COVID-19 residents or staff to the SD DOH. -She was aware certain diseases were mandated to be reported though. *She confirmed all staff and visitors should have been screened properly prior to entering the building. -That screening should have included temperature checks along with questions about symptoms, travel, or exposure to COVID-19. *She agreed there were not comprehensive and complete policies related to COVID-19 and there should have been. *The documentation had not supported staff training related to COVID-19 in general or updates related to it. -The 3/19/20 training appeared generalized for infection control and not all staff had completed that. -They had been giving staff additional training, but that was not documented. *There were no audits of staff related to infection control processes for COVID-19. *She stated they needed to work on their documentation overall to support what they were doing. *She confirmed the current COVID-19 pandemic had changes in the guidelines occurring frequently. -They should have been aware of and planning properly for the care and services related to it including documenting what was occurring and when.