DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING ______ B. WING ______	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	**402 S PINE STREET MENNO, SD 57045**

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/28/24 through 10/30/24. Menno-Olivet Care Center was found not in compliance with the following requirements: F641, F657, F658, and F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/28/24 through 10/30/24.The area surveyed was food palatability. Menno-Olivet Care Center was found in compliance.	F 000	F 641 Action Items 1. DON/MDS Coordinator reviewed Resident #6 and noted that resident was receiving Insulin Glargine Subcutaneous Pen-Injector 100 units/ml - 16 units two times daily since admission. This was corrected with a modification to Admission MDS with ARD 10/17/2024 and re-submitted on 10/29/2024. Resident #12 was utilizing Bed/ Chair silent alarm and items were coded as No in the most recent MDS. The previous MDS revealed correctly coded items of bed and chair alarm use daily. Bed/chair alarms were in use and noted to be in the residents' current plan of care.	12/13/24
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and the Centers for Medicaid and Medicare (CMS) Resident Assessment Instrument (RAI) Manual review, the provider failed to ensure the Minimum Data Set (MDS) assessments were coded accurately for: *One of one resident (6) who received insulin. *One of one resident (12) who had a bed alarm. Findings include: 1. Observation and interview on 10/29/24 at 9:24 a.m. with resident 6 revealed he was diabetic and received daily injections of insulin. Review of resident 6's electronic medical record	F 641	2. A 100% audit of the most recently completed MDS assessments for all residents who currently are utilizing bed/chair alarms was completed on 11/12/2024. No other residents currently utilizing bed/chair alarms. A 100% audit of the most recently completed MDS assessments for all residents who are currently receiving insulin was completed on 11/12/2024. Two of two residents coded correctly now (since modification of resident #6 MDS as previously mentioned. Only two residents in the current census as of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Kettwig	Administrator	11/21/24

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 641	Continued From page 1	F 641		

(EMR) revealed:
*He was admitted on 10/7/24.
*His 10/17/24 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated he was cognitively intact.
*A 10/7/24 physician's order for "Insulin Glargine Subcutaneous Solution Pen-injector
100 UNIT/ML [unit per milliliters] (Insulin Glargine) Inject 16 unit
subcutaneously two times a day."
*He had been administered that insulin injection as ordered two times a day.

Review of resident 6's 10/17/24 initial Minimum Data Set (MDS) assessment, section N (Medications) revealed:
*"Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days."
-It was marked "1".
*"Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days."
-It was marked "0 [zero]."
*"Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days."
-It was marked "0 [zero]."

Interview on 10/29/24 at 11:03 a.m. with director of nursing (DON) B regarding resident 6 revealed she:
*Was responsible for the completion of the MDS assessment.
*Confirmed resident 6 was on daily injections of

11.12.2024 receive insulin.
3. Both instances reflect that this could affect all residents. An audit of all MDSs of current residents was completed to review injections/ insulin received and any bed/chair alarm use on 11/12/2024. Resident #12 was the only resident with bed/chair alarm use.
4. An initial audit of each resident's most recent completed MDS will be completed by 12/06/2024 for any errors by all members of the interdisciplinary team. Then, any scheduled MDSs will be audited weekly for sixteen weeks to ensure a full quarter of MDSs captured. Each MDS will be audited for any error or discrepency upon completion by each member of the interdisciplinary team. Audits will be reported to QAPI. Members of the interdisciplinary team include MDS Coordinator/DON, Social Services, Restorative Nursing, Activity Director, Dietary Manager and Administrator. This plan will be communicated to the entire MDS team and Administrator for continued quality improvement across all areas throughout the MDS assessment. Each discipline will ensure accuracy of their section of the MDS. The QAPI team will determine if continued monitoring is required based upon audit results.

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F 641	Continued From page 2 insulin. *Confirmed that the MDS assessment did not accurately reflect that resident 6 had received insulin daily since he had been admitted. *She stated, "I will create the modification now. Thank you for catching that." 2. Observation on 10/28/24 at 4:51 p.m. of resident 12's room revealed: *He was not in his room. *His call light was clipped to itself against the wall in the center of the room. *The bed contained a bottom sheet and an incontinent pad. -A bed alarm pad was visible under the bottom sheet. Observation on 10/29/24 at 2:39 p.m. of resident 12's revealed: *He was in his bed. *His call light was clipped to itself against the wall in the center of the room. Review of resident 12's EMR revealed: *He was admitted on 7/26/21. *His 9/12/24 BIMS score was 6, which indicated he was severely cognitively impaired. *A 4/3/24 physician's order for "Bed/chair alarm in use for high fall risk. Review of resident 12's 9/12/24 quarterly MDS assessment, section P (Restraints and Alarms) revealed: *Bed alarm was coded as "Not used." *Chair alarm was coded as "Not used." Interview on 10/30/24 at 7:46 a.m. with DON B regarding resident 12 revealed: *Resident 12 had a bed and a chair alarm that he	F 641		

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F 641	Continued From page 3 used "at all times". -The alarms were "silent alarms" that notified the nurse and were "used as the call light so that when he gets up it alerts the staff." -They were assessed as an intervention and not as a restraint. *She confirmed that the bed and chair alarms had been coded on the previous MDS assessment. *She stated, "I missed it [coding of the alarm] on the last [9/12/24] MDS [assessment]." Review of the October 2023 CMS RAI Version 3.0 Manual Section N, Page N-1 revealed: *"The intent of the items in this section is to record the number of days, during the last seven days (or since admission/entry or reentry if less than 7 days) that any type of injunction, insulin, and/or selected medications were received by the resident." Review of the October 2023 CMS RAI Version 3.0 Manual Section P, Page P-8 revealed: *"An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair, and floor sensor pads..."	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657	F 657 Action Items 1. The DON addressed the care plan on 10/29/24 on resident #11 to update that the pressure ulcer focus was resolved as it was no longer a problem and it had healed. The care plan of resident #12 was updated as to contradictory call light placement in two separate areas within the care plan. One was removed from current care	12/13/24

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F 657	Continued From page 4 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and policy review, the provider failed to ensure resident care plans were revised to reflect the current needs of three of fifteen sampled residents (11, 12, and 21). Findings include: 1. Observation on 10/29/24 at 10:39 a.m. of resident 11's room revealed: *Her bed was up against the wall and had a wrap-around head and arm pillow with an air mattress on the bed. *A recliner was in the corner of the room and placed in the seat of the recliner were two heel protector booties. *In front of the recliner was an Omni-chair (Chair for pressure ulcer management).	F 657	plan of care on 10/30/24 in order to accurately reflect current care received to not place call light due to safety concern/issue. Care plan of resident #21 updated on 10/28/24 to remove the every fifteen minute location checks which should have been resolved upon discontinuation of the fifteen minute checks. 2. Audits will be done on all resident care plans by the interdisciplinary team and will be completed by 12/06/2024. During Risk Team meetings weekly, a review of all residents for any changes in status, new orders, updates on residents will be addressed/updated in the care plan by interdisciplinary team members. Audits will be completed by each member of the interdisciplinary team of all reviews and/or changes made to care plans weekly for sixteen weeks to ensure any changes or issues are addressed in the care plan. 3. Audits will be reported to QAPI and it will be at the discretion of the QAPI team to determine if continued monitoring is required based on audit results.	

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Review of resident 11's care plan on 10/29/24 revealed:
*An initiated 6/20/24 focus area that included, "[Resident 11] has an unstageable pressure ulcer to [her] right heel r/t [related to] limited mobility."
*The 6/20/24 goal for that focus area included:
- "Pressure ulcer will show signs of healing and remain free from infection by/through review date."
-"Monitor dressing daily to ensure it is intact and adhering."
-"The resident requires supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing."
- "Treat pain as per orders prior to treatment/turning etc. to ensure The resident's comfort."
- "Turn and Reposition at least Q [every] 2 hours when in bed. Change position throughout the day between Omni-chair. And w/c [wheelchair] (for meals) assist to lay in bed during the day."
- "[Resident 11] requires Pressure relieving/reducing device on bed."
- "Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate."

Review of the facility provided 10/28/24 Matrix did not indicate resident 11 had a pressure ulcer.

Interview on 10/29/24 at 3:35 p.m. with director of nursing (DON) B regarding resident 11's care plan revealed:
*She did not have a pressure ulcer on her right heel.
*DON confirmed the focus area for the pressure ulcer should have been resolved on her care plan.
2. Observation on 10/28/24 at 4:51 p.m. of

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resident 12's room revealed:
*He was not in his room.
*His call light was clipped to itself against the wall in the center of the room.

Review of resident 12's care plan revealed:
*"Be sure call light is within reach and encourage the resident to use it
for assistance as needed."
*"[Resident 2] does not utilize call light. Call light is a tripping hazard and risk for
strangulation for him. Staff are not to place call light by bed/chair due to this."

Interview on 10/30/24 at 7:46 a.m. with DON B regarding resident 12's care plan revealed she:
*Was responsible for updating his care plan.
*Confirmed both of the interventions above remained on his current care plan.
*Stated he was not to have a call light and when that changed, she had forgotten to remove the previous intervention.

3. Observation and interview on 10/28/24 at 4:31 p.m. with resident 21 revealed:
*She stated she had recently been hospitalized after experiencing side effects of a medication that caused her to "act funny."
-She recalled she had left the facility through her window.
*The window had been secured to make it more difficult to open.

Review of resident 21's care plan revealed:
*"[Resident 21 is an elopement risk/wanderer r/t [related to]
disoriented to place, Impaired safety awareness, delusional."
*"Monitor location every 15 min. Document

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wandering behavior and attempted diversional interventions."

Interview on 10/30/24 at 1:18 p.m. with DON B regarding resident 21's care plan revealed she:
*Confirmed both of the interventions above remained on her current care plan.
*Indicated care plans should be updated when the interventions change or after the facility "risk meeting."
*Stated, "I am good at putting them [interventions] on and not as good at taking the items off the care plan."
*Confirmed resident 21 remained an elopement risk but the intervention to monitor her location every 15 minutes had ended on 10/17/24.

Review of the providers' revised March 2022 Care Plans, Comprehensive Person-Centered policy revealed:
*"A comprehensive, person-centered care plan that includes measurable objectives in timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident."
*"The comprehensive, person-centered care plan:... describes the services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well being..."
*" The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the residence condition; b. when the desired outcome is not met; c. when the resident has been admitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment."

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F 658	Continued From page 8	F 658		12/13/24
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to assess one of one sampled resident (13) who self-administered medications to determine if she was able to do so appropriately and safely. Findings include: 1. Observation and interview on 10/29/24 at 8:51 a.m. with resident 13 revealed she: *Was sitting in her recliner eating her breakfast. *Had her morning medications in a medication cup on her bedside table. *Stated she eats her breakfast in her room. *Stated the nurses would bring her morning medications and leave it for her to take after she eats her breakfast. *Would have called the nurses if anything was wrong with her morning medications. *Stated when the nurses came back to pick up the breakfast tray, they made sure she had taken her morning medications. Interview and medication administration record (MAR) review on 10/29/24 at 9:05 a.m. with licensed practical nurse (LPN) E revealed resident 13 ' s 10/29/24 morning medications were documented as administered. Observation and interview on 10/30/24 at 8:40	F 658	F 658 Action Items 1. Resident #13 had not been assessed for Medication Self-Administration safety. Incorrect documentation of resident's ability to safely self-administer medications once set up for her as Assessment for Self-Administration of Medications should have been completed to ensure resident is able to safely self-administer medications after set-up by CMA/Nurse. Since this occurred, the care plan for resident #13 was updated and the intervention of "may self-administer medication after set-up by staff is now resolved on 11/13/2024 and resident will no longer have medications left in room to take without supervision until further determination can be made with clarification with provider, assessment, and resident cognitive status are all taken into consideration by the interdisciplinary team. CMA/ licensed nurse to administer medications at the preferred time/ request of the resident. CMA/ licensed nurse is to sign off on medications on the eMAR only after proper administration of medications. 2. Audits will be performed by the DON or designee of medication passes to ensure medication administration policies are followed across all shifts. These audits will be completed weekly for sixteen weeks. MDS Coordinator/DON or designee will review care plans weekly	

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F 658	Continued From page 9 a.m. with medication aide (MA) F regarding resident 13's ability to self-administer medications revealed resident 13 had been care planned for the medication aides to leave medications on the bedside table and then the medication aides would have returned to the resident's room to verify that the medications had been taken. Interview on 10/30/24 at 9:30 a.m. with MA F regarding resident 13 revealed: *MA F had documented resident 13 ' s medications as administered after she left them on the bedside table. *MA F had not verified resident 13 had taken those medications before she documented them as administered in the MAR. Reviewed of resident 13's EMR revealed: *She was admitted on 9/29/22 and had a Brief Interview for Mental Status (BIMS) assessment score of 13, which indicated she was cognitively intact. *Her diagnoses included: Alzheimer's disease, dementia, falls, and hypertension. *There was no documentation that indicated medication self-administration assessments were completed. Review of resident 13's current care plan on 10/29/24 revealed: *An initiated 5/30/24 focus area that included, "[Resident 13] has a behavior problem." *A 9/26/24 intervention included, "[Resident 13] wants to take her morning meds while eating." "She is capable of responsibly taking her medications once set up for her. CMA [certified medication aide] to check back with resident to ensure she has taken her meds." *An initiated 9/29/22 focus area that included,	F 658	for sixteen weeks to ensure medication self-administration assessment has been completed on any resident who self-administers any medication. Results of the audits will be reported to QAPI. The QAPI team will determine if continued monitoring is required based upon audit results.	

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"[Resident 13] has impaired cognitive function/dementia or impaired thought process r/t [related to] Dementia."
*The 9/29/22 goal for that focus area was, "[Resident 13] will develop skills to cope with cognitive decline and maintain safety by the review date."
--This goal was marked as revised on 6/14/24.
--The 9/29/22 intervention for that focus area included:
- "Ask yes/no questions in order to determine the resident's needs."
- "The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues-stop and return if agitated."
-"Cue, reorient and supervise as needed."
- "Present just one thought, idea, question, or command at a time.'
- "Use task segmentation to support short term memory deficits. Break tasks into one step at a time."

Interview on 10/30/24 at 2:40 p.m. with director of nursing (DON) B revealed she had thought the medication self-administration assessment only needed to be completed when the residents' kept bottles of medications in their rooms.

Review of the provider's revised August 2023 Self-Administration of Medications policy revealed:
*Policy Statement:
-"Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so."
*Policy Interpretation and Implementation:
1. "As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 11 assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.," 3. "If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and/or decision-making status." 5. "Residents are assessed upon initiation of self-administering medication, quarterly, and with any significant change in condition."	F 658		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812	F 812 Action Items 1. The walk-in cooler metal wire shelving located in the kitchen was immediately thoroughly cleaned by dietary staff to ensure the black substance noted to be on it was removed. The Administrator notified the flooring company on 11/18/2024 to discuss options regarding the walkin cooler flooring. Administrator and flooring company agreed that an inperson visit to view the flooring concerns would be beneficial. A meeting is planned for "sometime early December" but a more specific date and time would be determined once it got closer. Another business was considered to be contacted if current flooring company was unable to assist in this area. On 11.18.2024, the Dietary Manager, Administrator, Maintenance, and Dietician met inperson to discuss and determine what a long-term solution could be to provide a clean area for the food preparation countertop. After discussion, it was determined that for immediate resolution, the caulked area on the food preparation countertop in	12/13/24

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	435113	A. BUILDING ______ B. WING ______	C 10/30/2024

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MENNO-OLIVET CARE CENTER	402 S PINE STREET MENNO, SD 57045

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F 812	Continued From page 12 Based on observation, interview, and record review, the provider failed to maintain clean and sanitary conditions in one of one observed kitchen where residents' food was stored and prepared. Findings include: 1. Observation on 10/28/24 at 2:54 p.m. in the kitchen revealed: *The walk-in cooler metal wire shelving had a black substance on it. *The walk-in cooler flooring was a metal surface that contained rust and had a black substance on the caulking where the floor met the wall. *The caulked area on the food preparation counter where the countertop met the backsplash: -Had black and brown unidentified particles pressed into the caulking. -Was sticky when touched. *Area of the food preperation countertop were cracked and not sealed. *In the refrigerator there were: -A container of thickened orange juice had an expiration date of 7/6/24. -A container of tomato juice had an expiration date of 8/8/24. *Two containers of half and half had an expiration date of 10/13/24. *More than 12 containers of yogurt had a use by date of 10/20/24. 2. Interview on 10/29/24 at 2:30 p.m.with dietary manager C revealed: * The caulking on the food preparation counter had been recently replaced by the maintenance department. *She had asked for a new countertop and was told it would be too expensive. *She was not aware of the area of the countertop	F 812	the kitchen was removed by maintenance and the areas of concern were resealed. Food and drink products were examined by the dietary staff to determine if any items were outdated. All expired food and drink items discarded and replaced. 2. The Administrator, Dietary Manager, and Dietician reviewed and revised the current cleaning schedule for dietary cooks and dietary aides. Cleaning of the shelves in the walk-in cooler was modified to be cleaned weekly by dietary staff on the same day and same shift of every week to ensure consistency in cleaning responsibilities. Checking expiration dates weekly by dietary staff every week on the same day and same shift was added to the cleaning schedule to ensure that all food items and drink items are within the designated date to be considered safe for consumption. Any expired food or drink items are to be discarded immediately. Inspection of the caulked areas on the countertop will be done weekly by the Dietary Manager, or designee to ensure cleanliness of areas. If areas are noted to be concerning of uncleanliness, Dietary Mananger, or designee, will notify Maintenance immediately to have area addressed and to be maintained. The new hire orientation checklist will be updated by the Dietary Manager to include the cleaning schedule responsibilities and expectations. The Dietary Manager, or designee, will be responsible for providing this one-on-one training. 3. The updated cleaning schedules for dietary staff will be turned in to the Dietary Manager daily for review. The Administrator will fill in for reviewing cleaning schedules if Dietary Manager is absent. The Dietary Manager is to lead the dietary in-service on 11/21/2024 to review the changes made to the updated	

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	435113	A. BUILDING ______ B. WING ______	C 10/30/2024

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MENNO-OLIVET CARE CENTER	**402 S PINE STREET MENNO, SD 57045**

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F 812	Continued From page 13 that was not sealed. *She stated that there was a cleaning schedule for the kitchen and walk-in cooler. -The responsibility for cleaning would alternate between the morning and evening cooks. *It was her expectation that the wire shelves would be properly cleaned and signed off as completed each week. 3. Interview on 10/30/24 at 10:05 a.m. with administrator A revealed: *During a walk-though of the kitchen, she reported she had not been made aware of the condition of the countertop caulking. *She agreed that the caulking was not a cleanable surface. *She said this issue would be addressed. *She reported they were working with a flooring company on other projects and to see what could be done to fix the rusted floor in the walk-in cooler. 4. Review of the provider's weekly cleaning schedules revealed: *The task "Wipe shelves down in walk-in cooler" areas for week one and week two were signed off for the month of October, weeks three and four were not signed off as completed. *For the month of September, week one and week 5 were signed off as completed, weeks two, three, and four were not signed off as completed. 5. Review of the provider's November, 2022 Sanitization policy revealed: *Policy Interpretation and Implementation, number two, "All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect	F 812	cleaning schedules. A second in-service meeting for dietary staff is scheduled for 11.25.2024 and is to be led by the Dietary Manager and the Dietician on this date. The Dietary Manager, or designee will complete audits for ensuring that specific items on the cleaning schedule are being completed which includes the cleaning of the wire shelving in the walk-in cooler and for checking of the expired food and drinks Audits are to be done weekly for eight weeks, twice a month for four months, monthly for three months. All data will be reported to QAPI by the Dietary Manager, or designee. It will be at the discretion of the QAPI committee if the audits are to continue or if there has been correction of the deficient practice. The Administrator and Dietary Manager will do a weekly review of the audits to ensure that cleaning expectations are sustained and any expired food or drink items have been discarded. This weekly review will also include the monitoring of the caulked countertops to ensure they are being maintained and clean. This review will be reported to QAPI by the Administrator. 4. The Administrator reviewed with the Dietary Manager that our facility's process for facility improvement requests must be discussed directly with the Administrator and/or Board.	

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F 812	Continued From page 14 their use or proper cleaning." 6. Review of the provider's November 2022 Food Receiving and Storage policy revealed: *Refrigerated/Frozen Storage, number seven, "Refrigerated foods are labeled, dated and monitored so they are used by their "use-by" date, frozen, or discarded."	F 812		

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	435113	A. BUILDING ____ B. WING ____	10/29/2024

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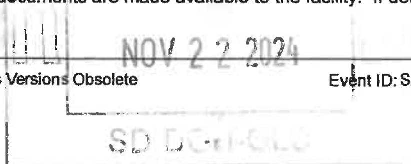
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 10/29/24. Menno-Olivet Care Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Kettwig

TITLE: Administrator

(X6) DATE: 11/21/2024

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.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	10/29/2024

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MENNO-OLIVET CARE CENTER	**402 S PINE STREET** **MENNO, SD 57045**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 10/29/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Menno-Olivet Care Center (Building 01) was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Kettwig	Administrator	11/21/2024

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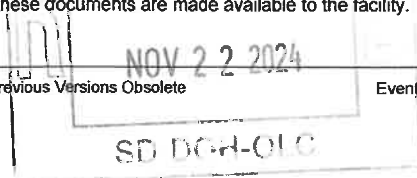

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/12/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING **02 - BUILDING 02** B. WING ______	**10/29/2024**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 10/29/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Menno-Olivet Care Center (Building 02) was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Kettwig
TITLE: Administrator
(X6) DATE: 11/21/2024

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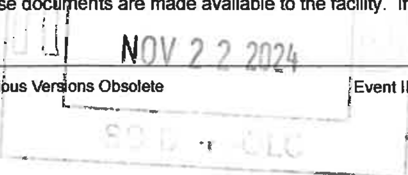

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING **03 - BUILDING 03** B. WING ______	**10/29/2024**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 10/29/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Menno-Olivet Care Center (Building 03) was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Kettwig	Administrator	11/21/2024

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10648	A. BUILDING: ______ B. WING ______	10/30/2024

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/28/24 through 10/30/24. Menno-Olivet Care Center was found in compliance	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 10/28/24 through 10/30/24. Menno-Olivet Care Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Kettwig	Administrator	11/21/2024