

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

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045	
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F 221	<p>Continued From page 1 table-top upon request from this surveyor.</p> <p>Interview on 7/22/14 at 8:35 a.m. with certified nursing assistant F regarding resident 6 revealed: *She had a diagnosis of dementia (forgetfulness) and did not talk appropriately. Her conversations had been to herself and were nonsensical and did not make sense. *She had a history of falls and required the use of a body pillow while resting in her bed. *She had not mentioned the required use of the half table-top while the resident was sitting in her w/c.</p> <p>Review of resident 6's 5/13/13 care plan revealed: *A focus area indicating she had been at risk for falls. *An intervention for her to be assisted to her recliner after meals as she would have fallen asleep in her w/c. *She had used a w/c for all of her mobility needs. *The half w/c table-top had not been listed as an intervention.</p> <p>No assessments or documentation had been located in her medical record to support the use of the half w/c table-top.</p> <p>Interview on 7/22/14 at 4:50 p.m. with restorative care aide (RCA) I regarding resident 6 revealed: *She had a history of leaning forward or to her right side when sitting in the w/c. *The half w/c table-top was to have helped her with positioning when sitting in the w/c. *The half w/c table-top had been initiated the end of June 2014 upon recommendations from the therapy department. *RCA I had no knowledge as to who had</p>	F 221	<p>(Con't from page 1)</p> <p>The Director of Nursing services will inservice on 8/20/14 that all nurses need to document in progress notes of the following:</p> <ol style="list-style-type: none"> 1. Positioning Problem 2. Order from the physician for positioning device. 3. Involvement of the Interdisciplinary Team necessity <p>The Director of Nursing services has notified on 8/19/14 that all Physical Therapists/Occupational Therapists need to document in progress notes of the following:</p> <ol style="list-style-type: none"> 1. Document the need for the positioning device. <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Director of Nursing Services, or designee, will monitor restraint assessment completion on a weekly basis beginning on 8/14/14 and monthly thereafter <i>*on everyone with a positioning device</i> <i>*report to quality Assurance Committee</i> Audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p>	

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F 221	<p>Continued From page 2</p> <p>requested the therapy department to assess the resident for the half w/c table-top.</p> <p>Interview on 7/23/14 at 9:35 a.m. with physical therapist (PT) H regarding resident 6 revealed: *The occupational therapy (OT) department had been requested by RCA I to screen resident 6 for a positioning device while sitting in her w/c. *The OT had been unavailable for interview. *She had a history of leaning to the right when sitting in the w/c. *There had been no documentation done by the therapy department to support the use of the half w/c table-top. *PT H had been unaware the half w/c table-top was considered a restraint.</p> <p>Interview on 7/23/14 at 2:10 p.m. with the Minimum Data Set (MDS) assessment coordinator regarding resident 6 revealed: *She had been aware the resident had been using a half w/c table-top to assist her with positioning in the w/c. *She had not been aware the half w/c table-top was considered a restraint. *She had not assessed the resident for the appropriate use of the half w/c table-top.</p> <p>2. Random observations from 7/22/14 through 7/24/14 of resident 8 revealed: *He had required the use of a Broda chair for mobility and appropriate body positioning. *There had been two thigh belts attached to the w/c. *Those straps had been wrapped around his legs to assist him with positioning. *There had been a headband attached to the top part of the Broda chair. *That headband had been wrapped around his</p>	F 221		

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F 221	<p>Continued From page 3 forehead when he was assisted with his meals.</p> <p>Review of resident 8's medical record revealed: *He had a disease that affected his memory and muscle control. *He had required full staff support for w/c positioning and eating. *He had no control over his body movements or head control. *He had required the use of the thigh belts for positioning in the Broda chair. *He had required the use of the headband for safety to support his head during meals. *There were no headband or thigh belt assessment forms found in his chart to support the use of them.</p> <p>Interview on 7/23/14 at 2:20 p.m. with the MDS coordinator revealed: *She had not been aware an assessment should have been completed to support the use of the headband or thigh belts. *She had never completed a restraint assessment form to validate the use of any restraint. *She confirmed a restraint assessment form should have been completed on all residents utilizing devices that had the potential for being considered a restraint.</p> <p>Interview on 7/24/14 at 11:20 a.m. with the director of nurses revealed she had not been aware an assessment form should have been completed on all residents utilizing devices that had the potential for being considered a restraint.</p> <p>Review of the provider's undated Restraint/Positioning Device policy revealed no procedure to ensure on-going assessments</p>	F 221		

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F 221	Continued From page 4 should have been completed on any restraint device.	F 221			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on interview, record review, and policy review, the provider failed to ensure 2 of 11 sampled residents (2 and 8) care plans were reviewed and revised to reflect their current care needs. Findings include: 1. Review of resident 8's complete medical record revealed:	F 280	483.20(d)(3),483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP Immediate action(s) taken for the resident(s) found to have been affected include: On 7/23/14 and 8/13/14, the MDS Coordinator/Director of Nursing Services updated the care plans for residents #2 & #8. Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected by this practice.	8/20/14	

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F 280	<p>Continued From page 5</p> <p>*He was admitted on 7/17/12.</p> <p>*His diagnoses had included a disease that affected his memory and muscle control, esophageal reflux (heartburn), and dysphagia (difficulty swallowing).</p> <p>*He required full staff support for meal and fluid assistance.</p> <p>*He had a history of refusing to eat breakfast.</p> <p>*He required the use of a headband during meals for safety and positioning.</p> <p>*He had no muscle control for his head.</p> <p>*A physician's order dated 6/17/14 "Pudding thick liquids."</p> <p>Review of resident 8's April 2013 care plan revealed:</p> <p>*He had a problem with swallowing thin liquids, was at risk for choking, and required his liquids to be nectar thick (like a creamed soup) in consistency.</p> <p>*He had required the use of a "feeder cup" for drinking his fluids.</p> <p>*He had been at risk for potential nutritional problems related to his forgetfulness and no muscle control, immobility, and refusing to eat breakfast.</p> <p>*The care plan had not indicated the correct physician's order of 6/17/14 for pudding thick liquids.</p> <p>*The care plan had not provided the use of the headband for safety and positioning during meal times.</p> <p>*The care plan had not indicated his risk for dehydration related to the assistance required from staff to obtain and drink his fluids.</p> <p>Interview on 7/23/14 at 10:00 a.m. with the Minimum Data Set (MDS) coordinator revealed:</p> <p>*Each member of the care plan team had been</p>	F 280	<p>(Con't from page 5)</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>The facility's MDS Interdisciplinary Team and licensed nurses will attend an inservice on 8/20/14 presented by the Director of Nursing Services to review the updated Care Plan Policy.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Director of Nursing Services, or designee, will monitor care plans daily for two weeks for those residents experiencing a change in status to ensure new or modified interventions have been addressed and documented regarding the resident's care. The Director of Nursing Services or designee will review a random sample of care plans one (1) time per week for one (1) month and every other week for one (1) month to assure the review and revision of care plans.</p> <p>Audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p>	

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F 280	<p>Continued From page 6 responsible for updating the care plans. *All care plans should have been updated as changes occurred for each resident. *The care plans had not been updated by the nurses. *The nurses were to have kept the care plan team informed of any changes that had occurred. *She agreed he was at a risk for dehydration and that should have been addressed on his care plan. *She had not been aware the headband was not documented on the care plan. He had been using that device for a long time. *She agreed the change in the consistency of his fluids on 6/9/14 should have been updated on the care plan. *She had agreed his care plan needed to have been updated in a timely manner.</p> <p>Interview on 7/24/14 at 11:25 a.m. with the director of nurses (DON) confirmed the above care plan had not been reviewed and revised to reflect his current needs and changes. She had agreed his care plan should have been updated in a timely manner.</p> <p>Surveyor: 32331 2. Review of resident 2's complete medical record revealed: *She was admitted on 10/11/13. *She had a history of significant weight loss and poor food intake. *She had a diagnoses that had included dementia (a mental change in the thinking process), depressive disorder, psychosis (a disturbance of the mind), insomnia (not able to sleep), and altered mental status. *A physician's order dated 6/27/14 for "2 Cal [Calorie] [a nutritional supplement]three times a</p>	F 280			

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F 280	<p>Continued From page 7 day for wt. [weight] loss given 3 OZ [ounce]."</p> <p>Review of resident 2's revised 6/18/14 care plan revealed: *She had a nutritional problem or potential nutritional problem related to: -Chewing problems. -Weight loss. -A diagnosis of dementia. *She had been refusing to eat. *She was on a regular mechanical soft diet. *She was on extra small servings. *She was on three oz 2 cal (a nutritional supplement) BID (twice per day). *The care plan did not indicate the correct physician ordered amount of 2 Cal at three times per day.</p> <p>Interview of 7/23/14 at 4:35 p.m. with the DON regarding resident 2's 6/18/14 care plan revealed she: *Agreed her care plan should have been updated to reflect the order for the 2 Cal. *Agreed she was at nutritional risk and had needed the extra nourishment. *Stated it was usually the MDS nurse that updated the care plan. *Stated it was the responsibility of any member of the care plan team for updating the care plan as needed.</p> <p>3. Review of the provider's December 2008 Care Planning policy revealed: **"Assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition change." **"The care planning/interdisciplinary team is responsible for the review and updating of care plans."</p>	F 280		

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure periodic smoking assessments were being completed on residents that smoked for one of one randomly selected resident (12) who smoked cigars. Findings include:</p> <p>1. Interview on 7/23/14 at 2:40 p.m. with the maintenance director revealed: *There was one resident (12) that smoked cigars. *There were no other residents that smoked cigars or cigarettes. *The facility was a smoke-free building and campus.</p> <p>Review of resident 12's medical record revealed: *He was admitted on 11/1/10. *There were no physician's orders for smoking cigars or cigarettes.</p> <p>Review of resident 12's revised 4/16/14 care plan revealed: *He would be able to go outdoors on a scooter to smoke when weather was good. *The scooter was to be made available with the</p>	F 323	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Smoking assessment for resident #12 completed on 7/23/14. Assessment revealed he was safe to smoke without supervision. Care plan was updated to reflect the assessment findings. Accident and supervision policy was updated. The attending physician was faxed for an order with resident's request to smoke.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The nursing management team reviewed the MDS Assessments for all residents who have been identified as having a potential risk for burns from smoking. Safety risk assessments are complete and interventions currently in place are appropriate.</p>	8/20/14

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F 323	<p>Continued From page 9 battery charged and in good repair.</p> <p>Review of resident 12's Smoking-Safety Screen completed on 7/23/14 revealed he: *Was independent to smoke without assistance when he left the facility on the scooter. *Was safe to smoke without supervision.</p> <p>Interview on 7/23/14 at 4:35 p.m. with the director of nursing regarding resident 12's smoking cigars revealed: *There had been no periodic smoking assessments completed. *She agreed there should have been periodic smoking assessments completed to determine safety for all residents that smoked. *She confirmed the only smoking assessment that had been completed since his admission was completed on 7/23/14. *She stated that assessment had been completed on 7/23/14 after this surveyor had asked if there had been any completed smoking assessments.</p> <p>Interview on 7/24/14 at 8:30 a.m. with the social services director regarding resident 12's smoking cigars revealed: *He kept his cigars and a lighter in his room. *He left the facility to smoke on the provider's electric scooter. *He usually checked himself out on the Resident Sign In/Sign Out Log at the front door. *He rode the scooter out on the public road and smoked by a building located next to the provider's back parking lot. *She stated he had not been going outside to smoke in the winter time. *She agreed that he had not been periodically assessed for safety with smoking.</p>	F 323	<p>(Con't from page 9)</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>All Licensed Nursing staff will be inserviced on 8/20/14 on the facility policy for Accidents and Supervision.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The MDS Coordinator, or designee, will review smoking assessments and care plans for those residents that smoke on a monthly basis for 6 weeks and quarterly thereafter.</p> <p>Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p>		

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F 323	Continued From page 10 Interview on 7/24/14 at 8:35 a.m. with resident 12 in his room revealed: *He kept his cigars and lighter in an unlocked wooden box. *He used the provider's scooter to go outside to smoke. *He stated he went out to smoke depending on the weather. *He stated he had not been going out when the temperature was cold or hot outside. Review of the provider's Resident Sign In/Sign Out Log in a white binder on a stand at the front entrance revealed resident 12's name written seven times for signing out of the facility since 6/29/14. Review of the undated Smoking Policy-Residents policy revealed the staff were to have reviewed the status of a resident's smoking privileges periodically, and consult as needed with the DON and the attending physician.	F 323			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (8) at risk for dehydration (not enough body fluid) had his fluid	F 327	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION Immediate action(s) taken for the resident(s) found to have been affected include: The Director of Nursing Services and Dietary Manager reassessed the hydration status and fluid needs for resident #8.	9/10/14	

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F 327	<p>Continued From page 11 needs met. Findings include:</p> <p>1. Random observations from 7/22/14 through 7/24/14 of resident 8 revealed: *He had been sitting up in a Broda chair (reclining wheelchair) in his room or at the dining room table. *He had been unable to make any body movements or mobility changes without the support of the staff. *He had been dependent upon the staff to assist him with all activities of daily living (ADL) including eating and drinking. *He had swallowing difficulties and required his fluids to be the consistency of pudding. *A six ounce (oz) glass of thickened water had been observed only once in his room during the above time frame.</p> <p>Interview on 7/23/14 at 1:55 p.m. with certified nursing assistant G regarding resident 8 revealed: *The dietary department delivered all of the fluids to the residents' rooms. *He had been a resident that required thickened liquids and would have only received a six oz cup of water. *The staff had tried to give him all of his fluids right away after they were delivered to his room. *He would not have been offered any more fluids in his room after the consumption of what had been brought to his room. *The dietary department delivered fluids and supplements to his room three times a day.</p> <p>Review of resident 8's 6/3/14 annual dietary review revealed: *He preferred to sleep in during the mornings and would not have come out for breakfast.</p>	F 327	<p>(Con't from page 11)</p> <p>All fluids provided on the resident tray at mealtime and at the resident's bedside were re-evaluated. Appropriate revisions were made to the care plan(s) to reflect current hydration interventions. The revised care plans were reviewed with staff involved in the care of the resident.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has determined that all residents have the potential to be affected.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>An in-service education program will be conducted on 9/10/14 by the Registered Dietitian with all direct care staff addressing the significance of accurate reporting of fluids consumed during meals, the need to encourage fluid intake, and the provision of sufficient intake between meals to maintain adequate hydration. The in-service also addressed the importance of reporting conditions that alter a resident's fluid needs.</p>		

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F 327	<p>Continued From page 12</p> <p>*A nutritional supplement was sent to his room. *It had not addressed his risk for dehydration, difficulties swallowing, requiring thickened liquids, and dependency on staff to assist him with drinking.</p> <p>Review of resident 8's 5/29/14 Minimum Data Set (MDS) assessment revealed he: *Was dependent upon staff with eating, drinking, and all ADLs. *Had a care area assessment focus area for hydration (fluid) needs. *Had problems with communication.</p> <p>Review of resident 8's daily fluid intake records from 5/27/14 through 5/29/14 revealed on: *5/27/14 he had consumed 680 milliliters (ml) of fluid that day. *5/28/14 he had consumed 1,580 ml of fluid that day. *5/29/14 he had consumed 1,300 ml of fluid that day. *At no other time had fluid intakes been documented.</p> <p>Review of resident 8's April 2014 care plan revealed: *He had been dependent upon staff for eating and mobility. *He had frequently refused breakfast in the past. *It had not addressed his risk for dehydration nor offered any staff interventions for that problem area.</p> <p>Interview on 7/23/14 at 4:15 p.m. with the dietary manager revealed: *All residents' fluid intakes had only been monitored during a window of time for their MDS assessments.</p>	F 327	<p>(Con't from page 12)</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The nursing management team, Registered Dietitian, and/or Dietary Manager will review each resident with risk factors for dehydration to ensure appropriate interventions are implemented and an updated plan of care is complete.</p> <p><i>* on 8/17/14 all residents identified at risk for dehydration</i> The MDS Coordinator, or designee, will complete random weekly chart audits for six (6) consecutive weeks beginning 8/17/14 and review all fluid intake records to ensure that appropriate interventions have been put in place to reduce the risk of dehydration. Audits will assure that care plans remain updated to reflect these interventions.</p> <p>Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p> <p><i>* MDS coordinator or designee will monitor and report results to quality assurance committee.</i></p>	

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F 327	<p>Continued From page 13</p> <p>*That window of time frame for monitoring and documenting for his fluid intake was only three days.</p> <p>*She had not monitored any residents' fluid intakes outside of those three days.</p> <p>*The fluids given in the resident's room had been documented by the CNAs electronically.</p> <p>*The fluids given during meals in the three day window time frame had been documented on a paper form located in the dining room.</p> <p>*Dietary supplied all fluids delivered to the residents' rooms.</p> <p>*Resident 8 had nutritional supplements along with his six oz of water delivered to his room three times a day. The six oz had been considered only four oz of water due to the thickening additive.</p> <p>*Daily fluid requirements for a resident were thirty cubic centimeters (cc) per kilogram (1 kilogram of measurement equals 2.2 pounds) of body weight.</p> <p>*Fluid requirements for resident 8 should have been 2,300 to 2,700 cc per day based on his current body weight of 200.4 pounds.</p> <p>*She had agreed the amount of recorded fluids for resident 8 had not met his daily fluid requirements.</p> <p>Review of the provider's December 2011 Resident Hydration and Prevention of Dehydration policy revealed: ***If potential inadequate intake and/or signs and symptoms of dehydration are observed, intake and output monitoring will be initiated incorporated into the care plan." ***Nursing will monitor and document fluid intake and the dietary manager will be kept informed of status. Interdisciplinary team will update care plan and document resident response to interventions until team agrees that fluid intake and relating</p>	F 327			

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F 327	Continued From page 14 factors are resolved."	F 327		
F 329 SS=E	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 A. Based on record review, interview, and policy review, the provider failed to ensure psychotropic medication (mood altering) used for two of two sampled residents (1 and 8) had the appropriate documentation to support the use without a</p>	F 329	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>The attending physician for resident #2 was requested on 8/19/14 to discontinue the PRN for Haldol.</p> <p>Identification of other residents having the potential to be affected was accomplished by: *All residents taking psychotropic medications were reviewed. Identified was any resident with psychotropic medications. <i>DW/SDCOH/MTF</i></p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>The Director of Nursing services educated the consulting pharmacist on 8/19/14 to inform him of his need to properly document effectiveness and rationale for use of psychotropic medications. The Director of Nursing services contacted the Medical Director and discussed the need for her to educate all physician staff practicing in the facility regarding the proper documentation for and use of psychotropic medication and gradual dose reduction.</p>	8/20/14

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F 329	<p>Continued From page 15 gradual dose reduction (GDR) review by the pharmacist and physician. Findings include:</p> <p>1. Review of resident 8's complete medical record revealed: *He was admitted on 7/17/12. *He had diagnoses that had included memory loss with no muscle control, depression (sadness), personality disorder (behaviors different from society expectations), aggression, and dementia (forgetfulness). *He had physician's orders for the following medications: -Paxil (antidepressant) 30 milligrams (mg) everyday for depression with a start date of 3/25/13. -Trazodone (antidepressant) 50 mg everyday for depression 3/25/13. -Ativan (antianxiety) 1 mg four times a day (QID). Was decreased to 0.5 mg QID on 6/9/14. -Olanzapine (antipsychotic) 10 mg two times a day for mood and behavior with a start date of 7/2/13.</p> <p>Review of resident 8's revised April 2013 care plan revealed he took psychotropic medications due to his disease affecting his memory and muscle control and personality changes. The director of nurses (DON) and the pharmacist were to have reviewed those medications every sixty days.</p> <p>Review of resident 8's July 2014 medication administration record confirmed he had taken all of the above prescribed medications with those start dates.</p> <p>Review of resident 8's interdisciplinary progress notes from March 2014 through June 2014</p>	F 329	<p>(Con't from page 15)</p> <p>The policy for Medication Drug Regimen was updated as well as the Gradual Dose Reduction Schedule. <i>[Redacted]</i> <i>[Redacted]</i> DWISDDOH/MF</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Director of Nursing Services, or designee, will review physician progress notes for proper documentation of the psychotropic medications after each resident recertification visit. Monitoring will continue indefinitely.</p> <p>The Director of Nursing Services, or designee, will review pharmacist's progress notes for proper documentation of the effectiveness and rationale for psychotropic medications after each monthly pharmacy review. Monitoring will continue indefinitely.</p> <p>* Audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. <i>Director of Nursing Services or designee will report results to the Quality Assurance Committee. DWISDDOH/MF</i></p>	

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F 329	<p>Continued From page 16 revealed:</p> <ul style="list-style-type: none"> *He had taken the above prescribed antipsychotics. *He had not been exhibiting any behaviors and his uncontrolled movements had been minimal. *There were no documented reasons for giving the above medications. <p>Review of resident 8's physician's progress notes from July 2013 through June 2014 revealed:</p> <ul style="list-style-type: none"> *He had the above diagnoses with no new acute issues. *He was to continue with current medications. *The Ativan was to have been decreased on 6/9/14. *No documentation to support the use of two antidepressants, an antianxiety, and an antipsychotic without an attempt for a dose reduction this past year. *No changes had been made by the physician for a dose reduction or medication change for the above medications except the Ativan. <p>Review of resident 8's pharmacy consultant's Monthly Medication Chart Review from July 2013 through June 2014 revealed no documentation to support the use or effectiveness for mood altering medications or duplicate drug therapy. The physician had decreased resident 8's Ativan per the pharmacist's recommendations on 6/9/14. No changes or further recommendations for dose reductions had been made this past year by the pharmacist.</p> <p>Interview on 7/24/14 at 11:30 a.m. with the director of nurses (DON) regarding resident 8's antipsychotic medications revealed:</p> <ul style="list-style-type: none"> *Those above medications had been typical for a person with his disease. 	F 329	<p>*The physician for residents 1 and 8 were notified and will provide documentation as to the rationale for not engaging in gradual dose reductions. The documentation will be available on the residents records by 9/12/14. DW/SD/BN/RF</p>		

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F 329	<p>Continued From page 17</p> <p>*She and the pharmacist reviewed the resident's medications monthly.</p> <p>*She had been documenting in a separate book when the pharmacist had made any recommendations.</p> <p>*She had not been aware the pharmacist and physician should have been documenting the effectiveness and rationale for the above medications without a dose reduction.</p> <p>Preceptor: 32355 Surveyor: 34030</p> <p>2. Review of resident 1's complete medical records revealed:</p> <p>*He was admitted on 9/17/12.</p> <p>*His diagnosis had included episodic mood disorder (a periodic inability to control his actions).</p> <p>*He was on three psychotropic medications.</p> <p>-Risperdal, started 9/9/13.</p> <p>-Lithium, started 7/30/13.</p> <p>-Clozapine, started 3/14/13.</p> <p>*No mention of the indication for continued use of those medications by his physician were found.</p> <p>Review of resident 1's revised July 2014 care plan revealed:</p> <p>*He was on the above medications for mood disorder.</p> <p>*The DON and the consultant pharmacist were to have reviewed those medications every sixty days.</p> <p>Review of resident 1's Monthly Medication Chart Review by the consultant pharmacist for 7/16/13 through 7/22/14 revealed there were no recommendations for changes or potential problems noted for the above medications.</p>	F 329		

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F 329	<p>Continued From page 18</p> <p>Interview on 7/24/14 at 11:30 a.m. with the DON regarding resident 1's psychotropic medications revealed:</p> <ul style="list-style-type: none"> *She and the consultant pharmacist reviewed medications monthly. *She was not aware the pharmacist and the physician should have documented the effectiveness and rationale for the above medications. <p>Surveyor: 34030</p> <p>Surveyor: 32331</p> <p>B. Based on record review, interview, observation, and policy review, the provider failed to identify the use of an unnecessary drug on a PRN (whenever necessary) schedule for one of six residents (2) with behaviors who was on haloperidol, an antipsychotic medication (used in the treatment of psychotic disorders). Findings include:</p> <p>1. Review of resident 2's complete medical record revealed:</p> <ul style="list-style-type: none"> *She was admitted on 10/11/13. *She had a history of falls. *She had a history of significant weight loss and poor food intake. *She had diagnoses that had included dementia (forgetfulness), depressive disorder, psychosis (a disturbance of the mind), insomnia (unable to sleep), and altered mental status. *A physician's order dated 2/28/14 "Haloperidol Tablet 2 mg [milligrams] Give 2 mg by mouth as needed for Behaviors related to Dementia, unspecified, with behavioral disturbance (294.21) [a diagnosis code] BID [twice per day] PRN [whenever necessary]." *A physician's Progress Note on 6/9/14 revealed 	F 329			

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F 329	<p>Continued From page 19 she had reacted to antipsychotics in the past.</p> <p>Review of resident 2's medication administration records from 3/1/14 through 7/21/14 revealed the antipsychotic medication haloperidol on a PRN basis was used: *Two times in March 2014 on 3/01/14 and 3/06/14. *Three times in July 2014 on 7/18/14, 7/19/14, and 7/21/14.</p> <p>Review of resident 2's Progress Notes for 7/18/14 through 7/21/14 revealed she had been given a haloperidol tablet 2 mg for behaviors related to dementia, unspecified, with behavioral disturbance on: *7/18/14 at 8:08 p.m. *7/19/14 at 6:56 p.m. *7/21/14 at 7:32 p.m. "given per nurse request for behaviors." *There were no documented reasons for giving the medication by nursing in the Progress Notes on 7/18/14 and 7/19/14.</p> <p>Review of resident 2's Behavior Symptoms log for 7/1/14 through 7/23/14 revealed on: *7/18/14 there were no behavior symptoms documented at any time during the day. *7/19/14 there were no behavior symptoms documented at any time during the day. *7/21/14 there were behavior symptoms of yelling/screaming documented at 9:48 p.m.</p> <p>Interview on 7/23/14 at 4:35 p.m. with the director of nursing (DON) regarding resident 2's PRN order of the antipsychotic medication haloperidol revealed she stated: *The resident had a diagnosis that included psychosis.</p>	F 329		

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F 329	<p>Continued From page 20</p> <p>*The consultant pharmacist reviewed her medications with the physician's recertification every sixty days.</p> <p>*Other medications had been tried, and the haloperidol was the most effective with her behaviors.</p> <p>Interview on 7/24/14 at 11:25 a.m. with the Minimum Data Set (MDS) coordinator regarding resident 2's PRN order given for the haloperidol medication revealed she stated there was:</p> <p>*No nursing documentation for the reason it had been given on 7/18/14 and 7/19/14 according to the Behavior Symptoms log.</p> <p>*Limited documentation as to the reason on 7/21/14 the medication was given with "per nurse request for behaviors. "</p> <p>Review of resident 2's revised 6/18/14 care plan revealed:</p> <p>*She was dependent on staff for meeting emotional, intellectual (thinking), physical, and social needs related to dementia.</p> <p>*Medication was to have been reviewed by the DON and the pharmacist every sixty days to monitor laboratory test results, contraindications, and poly-pharmacy (duplicate medications).</p> <p>*There were no non-medication interventions listed for the behaviors.</p> <p>*Any adverse reactions of the psychotropic medication were to have been monitored, documented, and reported by the certified nursing assistant whenever necessary including:</p> <ul style="list-style-type: none"> -Frequent falls. -Refusal to eat. -Depression. -Insomnia. -Loss of appetite. -Weight loss. 	F 329		

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F 329	<p>Continued From page 21</p> <p>-Behavior symptoms not usual to the person.</p> <p>Review of resident 2's Weights and Vitals Summary sheet from 10/15/13 through 7/23/14 revealed: *A total weight loss of 43.2 pounds (lb) from her admission weight on 10/15/13. *Her admission weight on 10/15/13 was 184 lb. *Her weight on 7/23/14 was 140.8 lb. *An adverse reaction to the psychotropic medication on her care plan had included weight loss.</p> <p>Review of resident 2's Nutrition Report for 7/1/14 through 7/22/14 revealed: *An average meal intake of 38 to 40 percent. *An adverse reaction to the psychotropic medication on her care plan had included loss of appetite.</p> <p>Observation on 7/22/14 at 5:45 p.m. of resident 2 in the dining room revealed: *She ate none of her evening meal. She had refused it. *An adverse reaction to the psychotropic medication on her care plan had included refusal to eat.</p> <p>Review of resident 2's Monthly Medication Chart Review by the consultant pharmacist for 10/22/13 through 6/24/14 for the antipsychotic medication haloperidol revealed there were: *No recommendations for changes. *No potential problems were found for the usage.</p> <p>Todd P. Semla et al., Geriatric Dosage Handbook, 16th Ed., American Pharmacists Association, Hudson, Ohio, 2011, p. 813, revealed the antipsychotic medication,</p>	F 329		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2014
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F 329	<p>Continued From page 22</p> <p>haloperidol, has not been approved for the treatment of dementia-related psychosis.</p> <p>Surveyor: 32355 Review of the provider's January 2004 Medication-Drug Regimen Review policy revealed: **"It is the policy of Menno-Olivet Care Center that each resident's drug regimen be free from unnecessary drugs." **"The pharmacist shall review the drug regimen of each resident at least bi-monthly and report any irregularities or unnecessary drugs to the DON and the attending physician." *Definition of unnecessary drugs: "Drugs that are given in excessive doses, for excessive periods of time, without adequate monitoring." **"The pharmacist shall review each resident's drug regimen and associated factors in sufficient detail to determine if any irregularities or unnecessary drugs exist."</p> <p>Review of the provider's April 2007 Tapering Medications and Gradual Drug Dose Reduction (GDR) policy revealed: **"All medications shall be considered for possible tapering. Tapering that is applicable to antipsychotic medications shall be referred to as gradual dose reduction." **"Periodically the staff and practitioner will review the continued relevance of each resident's medications." **"The physician will review periodically [medical provider] whether current medications are still necessary in their current doses." **"Within the first year after a resident is admitted on an antipsychotic medication or after the resident has been started on an antipsychotic medication, the staff and practitioner shall</p>	F 329		

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F 329 F 371 SS=F	Continued From page 23 attempt a GDR in two separate quarters." 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, testing, record review, product information review, and policy review, the provider failed to maintain sanitation in the kitchen with the potential of cross-contamination (bacteria transferred from one area to another) in the following areas: *Proper sanitizing of the wiping cloths for one of three meal observations in the kitchen. *The shelves used to store dishes were free from unfinished wood (an uncleanable surface) in three of four cupboards in the kitchen. Findings include: 1.Observation and testing on 7/22/14 at 11:30 a.m. in the kitchen revealed a red sanitizing bucket in one sink of the three compartment sink. Testing of the liquid in that bucket revealed: *There were two wet cloths in the clear liquid. *The liquid in the bucket using a Hydrion 40 test strip (a type of special paper) tested at zero parts	F 329 F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE- SANITARY Observation #1 Immediate action(s) taken for the resident(s) found to have been affected include: The Dietary Manager contacted the manufacturer of the sanitizing unit on 7/23/14 to notify manufacturer of unit malfunction. Adjustments were made to the unit that day which produced the correct ppm for disinfection. The unit was serviced on 8/13/14 by the manufacturer representative and a new part installed to ensure proper ppm of disinfection agent. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected.	8/20/14

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F 371	<p>Continued From page 24 per million (ppm). *That test revealed no sanitizer in the sanitizing bucket.</p> <p>Observation and testing on 7/22/14 at 11:31 a.m. in the kitchen of the Oasis 146 Multi-Quat (quaternary) Sanitizer dispenser attached to the wall located above the three compartment sink revealed: *The sanitizer out of of the dispenser was tested using a Hydrion 40 test strip with a result of less than 100 ppm. *That same sanitizer liquid was an opaque-colored liquid. *The sanitizer liquid in the dispensing product container on the floor below the three compartment sink was an orange-colored liquid.</p> <p>Interview on 7/22/14 during the above time in the kitchen with cook M regarding the red sanitizing bucket revealed she had changed the bucket's solution one-half hour earlier.</p> <p>Interview on 7/22/14 at the above time with the dietary manger (DM) regarding the red sanitizing bucket in the kitchen and the Oasis 146 Multi-Quat Sanitizer dispenser revealed she: *Agreed that both the sanitizing bucket and the sanitizer liquid coming out of the dispenser needed to have been at a higher ppm for proper sanitizing. *Stated the bucket that contained the wet cloths was used to wipe down the residents' tables in the dining room, the kitchen production tables and counters, and other surfaces in the kitchen. *Agreed the sanitizer was not sanitizing properly.</p> <p>Interview on 7/22/14 at 3:30 p.m. with the DM and the maintenance supervisor regarding the red</p>	F 371	<p>(Con't from page 24)</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>The Dietary Manager will provide additional education to dietary staff on 8/20/14 regarding the necessity to immediately notify the department manager if a ppm reading is below the acceptable level.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>Beginning 8/20/14, the Dietary Manager, or designee, will review a sample of the daily monitoring at a minimum of one time per week for 2 months.</p> <p>Audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. *Dietary manager or designee will report to QA. The facility's current procedure is to test the ppm in the buckets daily & record the results. Staff is to correct low levels at the time discovered.</p>		

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F 371	<p>Continued From page 25</p> <p>sanitizing bucket and the Oasis 146 Multi-Quat Sanitizer dispenser revealed: *The level of the sanitizing bucket liquid and the sanitizer dispenser were now at 200 ppm. *They stated the sanitizer dispenser had not been working properly. *The maintenance director stated the dispenser had needed to be adjusted where the needle and the tubing took the sanitizer out of the dispensing product container. *They were unsure on how long that had been occurring, and the sanitizer dispenser had not been working properly.</p> <p>Record review on 7/22/14 of the provider's 5/17/14 through 7/21/14 Sanitizer Log for the Dishmachine and Sani [Sanitizing] Pail revealed: *There was no sanitizing pail ppm recorded for 7/22/14. *A level of 100 ppm on 5/27/14 revealed no documentation that showed a follow-up and correction of the low level. *Daily checks of the sanitizing pails ppm were missing for the following: -On 5/22/14. -Eleven times in June 2014. -Eleven times in July 2014.</p> <p>Interview on 7/23/14 at 2:50 p.m. by telephone with an EcoLab sales representative revealed: *The Oasis Multi-Quat 146 Sanitizer needed to have been at no less than 150 to 200 ppm for an acceptable range for sanitizing. *A level of 100 ppm or less was not an acceptable level for proper sanitizing.</p> <p>Review of the provider's undated Product Specification Document of the Oasis 146 Multi-Quat Sanitizer revealed it:</p>	F 371	<p>(Con't from page 25)</p> <p>Observation #2</p> <p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>On 7/29/14, the shelves were covered with a plexi-glass material in order to create a cleanable surface.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has determined that all residents have the potential to be affected.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>The Dietary Manager will ensure proper monitoring of surface to ensure it remains a cleanable surface.</p>	

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F 371	<p>Continued From page 26</p> <p>*Could be used to sanitize hard, non-porous food contact surfaces such as tables, counters, and food processing equipment.</p> <p>*Was an effective sanitizer on food contact surfaces when used at 150 to 400 ppm active quat.</p> <p>*Was to have been exposed to surfaces as a sanitizing solution for a period of not less than one minute.</p> <p>Review of the provider's November 2010 Three Compartment Sink Sanitizer Concentration policy revealed:</p> <p>*The sanitizer concentration was to have been checked to ensure the correct solution was being utilized for sanitation purposes.</p> <p>*The concentration of the sanitizer was to have also been recorded.</p> <p>*Each dishwasher staff person was responsible for checking the concentration daily.</p> <p>*The supervisor was to have checked the sanitized water and chart at random to be sure it was accurate.</p> <p>*The concentration was checked using a sanitizer strip and compared to the tape with the color chart, and results recorded.</p> <p>2.Observation on 7/22/14 at 11:53 a.m. in the kitchen in three of the four cupboards above a serving counter that contained clean dishes revealed:</p> <p>*Raw, unfinished wood on the three shelves inside each of the cupboards.</p> <p>*Those shelves contained clean dishes.</p> <p>*On two of those shelves there were plastic bowls, glasses, and cups stored in an inverted (turned over) position with the rims of the dishes laying directly on the unfinished wood.</p> <p>*The shelves were an uncleanable surface.</p>	F 371	<p>(Con't from page 26)</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>Beginning 8/20/14, the Dietary Manager, or designee, will conduct monthly spot checks of the shelving area identified and report findings to the Quality Assurance Committee monthly.</p> <p>Audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p>		

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F 371	Continued From page 27 Interview on 7/23/14 at 2:30 p.m. with the maintenance supervisor and at 4:00 p.m. with the DM regarding the cupboards above the serving counter that contained clean dishes revealed: *They agreed the shelves were an uncleanable surface. *The clean dishes that had been stored there were exposed to an uncleanable surface that had a potential for cross-contamination. Review of the provider's November 2010 Handling Clean Equipment and Utensils policy revealed: *Clean equipment and utensils were handled to prevent contamination. *Those items would be stored in a clean, dry location in a way that protected them from contamination. *Glasses and cups were to be stored in an inverted position.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS Observation #1 Immediate action(s) taken for the resident(s) found to have been affected include: *Resident 3 DWISDDOH/MF The resident with suprapubic catheter was identified and an alternate method of bathing was commenced on 7/24/14. Identification of other residents having the potential to be affected was accomplished by:	8/20/14

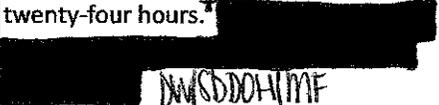
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F 441	<p>Continued From page 28 actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 27473 A. Based on observation, interview, bath policy review, manufacturer's reference source review, and National Institutes of Health (NIH) reference resource review, the provider failed to ensure one of one sampled resident (3) with a suprapubic (a tube inserted into the abdomen to drain urine from the bladder) urinary catheter was not submerged in a whirlpool tub. Findings include:</p> <p>1. Observation and interview on 7/23/14 at 2:15 p.m. with certified nurse assistant (CNA) F revealed she: *She was one of the bath aides.</p>	F 441	<p>(Con't from page 28)</p> <p>Also identified was any resident with a urinary or suprapubic catheter identified at risk for potential infection if bathed in whirlpool tub.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>The Director of Nursing services educated that bath aides/CNA's on the CDC recommendation to shower any resident with an indwelling urinary or suprapubic catheter. The Suprapubic catheter policy was updated on 8/19/14.</p> <p>A 'Bath Aides Expectations' sheet was updated to include: "Per CDC recommendations: Residents with catheters will receive showers".</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Director of Nursing Services, or designee, will monitor bathing of resident(s) with suprapubic catheter to assure shower was given weekly for 6 weeks beginning on 7/28/14 and monthly thereafter.</p>	

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F 441	<p>Continued From page 29</p> <p>*She had been trained by another aide some time ago in how to operate, clean, and maintain the whirlpool tub..</p> <p>*She proceeded to disinfect and clean the Parker Bath from Arjo demonstrating the many features of the whirlpool tub.</p> <p>*When asked she indicated the water line would be approximately six inches from the rim of the tub when a resident was seated/reclined in the tub.</p> <p>*When asked if residents with urinary catheters were bathed in the tub she responded with "Yes," and proceeded to say resident 3 was bathed in the tub on Mondays. He was bathed first in the morning. She indicated a catheter plug was used to allow the catheter tubing to be disconnected during the time of the bath.</p> <p>Review of the January 2013 Bathing policy revealed there was no mention of bathing or how to bathe an individual with a urinary catheter.</p> <p>According to the NIH regarding bathing a person with an indwelling catheter: "sitting in the tub, however, is not recommended." http://www.cc.nih.gov/cc/patient_education/pepubs/bladder/foley5_17.pdf accessed 7/25/14.</p> <p>Review of the manufacturer's reference materials for the Parker Bath from Arjo revealed no information about bathing or how to bathe an individual with a urinary catheter.</p> <p>Interview on 7/23/14 at 4:15 p.m. with the infection control nurse confirmed and revealed: *She was not aware of any additional facility policy regarding bathing of a resident with a catheter. *She was not aware of the NIH recommendation</p>	F 441	<p>(Con't from page 29)</p> <p>Audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p> <p>Observation #2</p> <p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>The Housekeeping Supervisor updated the policy "Clostridium Difficile" to indicate that the proper ratio for bleach solution was one part bleach and 9 parts water to comply with APIC (Association for Professionals in Infection Control and Epidemiology, Inc.) Guide to Preventing Clostridium difficile Infections, 2013. The policy was also updated to indicate that a mixed bleach solution is only good for twenty-four hours.*</p> <p> DMSDDHMF</p>	

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F 441	<p>Continued From page 30</p> <p>for an individual with a catheter to not sit in a tub for bathing.</p> <p>Interview on 7/24/14 at 8:20 a.m. with the director of nurses confirmed and revealed: *There was no mention in the facility bathing policy about residents with a catheter. *She was not aware of the NIH recommendation for an individual with a catheter to not sit in a tub.</p> <p>Surveyor: 32331 B. Based on observation, interview, and policy review, the provider failed to ensure the chlorine (bleach) disinfectant used on three of three resident wings (100, 200, and 300) located on two of two housekeeping carts was prepared fresh daily to maintain its effectiveness and in the correct dilution for killing the bacteria clostridium difficile (C. Diff, an infection in the bowel). Findings include:</p> <p>1.Observation and interview on 7/23/14 at 9:15 a.m. with housekeeping staff person L at the housekeeping cart on the 100 wing revealed: *A 550 cubic centimeter (cc) spray bottle with a handwritten label "1 part Bleach to 10 parts Water" that contained 250 cc of a clear liquid. *There was not a date on that spray bottle. *She stated she could not recall the last time the solution had been prepared. *She stated it had been "at least one or two weeks" since it had been prepared. *She stated she had been using the solution in the spray bottle in the residents' bathrooms on the 100 and 200 wings. *She stated the prepared ratio of chlorine to water was 1 part chlorine to 10 parts water in the spray</p>	F 441	<p>(Con't from page 30)</p> <p>On 8/18/14, the Housekeeping Supervisor ensured the bottles containing the bleach solution were properly labeled with the date solution mixed, contents of mixture, and appropriate handling label.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has determined that all residents have the potential to be affected.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>The Housekeeping Supervisor will ensure proper re-training of housekeeping staff at the inservice on 8/20/14. Records of attendance will be kept.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p>	

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F 441	<p>Continued From page 31 bottle.</p> <p>Observation and interview on 7/23/14 at 9:18 a.m. with housekeeping staff person L at the housekeeping cart on the 300 wing in a janitor's closet labeled "Custodial" revealed: *A 355 cc spray bottle with a handwritten label "1:10 Bleach/Water" that contained 180 cc of a clear liquid. *There was not a date on that spray bottle. *She stated she could not recall the last time the solution had been prepared. *She stated it had been "at least one or two weeks" since it had been prepared. *She stated she had been using the solution in the spray bottle in the residents' bathrooms on the 300 wing. *She indicated she would have used the prepared bleach solution on surfaces in residents rooms if there had been residents with C. Diff. *She was not aware of the chlorine parts per million (ppm) that was needed to be effective for proper disinfection. *She stated the prepared ratio of chlorine to water was one part chlorine to ten parts water in the spray bottle. *The ratio was to have been one part chlorine to nine parts water for proper disinfecting for C. Diff.</p> <p>Interview on 7/23/14 at 10:55 a.m. with the infection control nurse revealed: *She stated the ratio was to have been one part chlorine to ten parts water for proper disinfecting. *She stated the bleach solution was to have been made within twenty-four hours to maintain the effectiveness of the solution. *She confirmed there needed to have been a date on each of the spray bottles. *She agreed the solution had not been prepared</p>	F 441	<p>(Con't from page 31)</p> <p>Beginning 8/20/14, the Housekeeping Supervisor, or designee, will conduct spot checks of bleach solution mixing at a minimum of 4 times monthly and report the findings to the Quality Assurance Committee monthly.</p> <p>Audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p>		

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NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE. 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045		
(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 441	<p>Continued From page 32 properly had there been any C. Diff residents.</p> <p>Interview on 7/23/14 at 4:55 p.m. with the director of nursing confirmed she would have expected the bleach solution to have been made properly.</p> <p>Review of the provider's undated Reference Guide for Dilution from housekeeping revealed: *"Bleach water-10 oz [ounces] of water to 1 oz of bleach." -That amount listed above would have provided one part of bleach to ten parts of water. *The amount needed to have provided one part bleach mixed with nine parts of water on the policy. *There were no directions on the policy on how frequent the bleach solution was to have been prepared.</p> <p>Review of the provider's 2010 Clostridium Difficile policy for housekeeping revealed: *To have cleaned bathrooms and toilets of all suspected and confirmed cases of C. Diff in order to prevent the spread of infection. *Directions on how to have prepared the bleach solution were written as follows: -"1. A 1:10 bleach solution (1/2 cup bleach and 5 cups water) will be used for cleaning the inside and outside of the toilet of infected resident. -2. Area should be sprayed thoroughly, wetting all surfaces with the solution, let stand for 10 minutes, then wipe with a clean cloth. -3. Inside of toilet bowl, bleach should be added, scrub with toilet brush and let stand for 10 minutes. -4. Other high touch areas in the bathroom and room should be disinfected in the same manner with the same contact time." *That amount listed above would have provided</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2014
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045		
(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 441	Continued From page 33 one part of bleach to ten parts of water. *There were no directions on the policy on how frequent the bleach solution was to have been prepared. APIC (Association for Professionals in Infection Control and Epidemiology, Inc.) Guide to Preventing Clostridium difficile Infections, 2013, Washington, D.C., p. 51, revealed the use of a ten percent sodium hypochlorite (bleach) solution mixed fresh daily with one part chlorine bleach mixed with nine parts tap water had been associated with a reduction in C. Diff.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 27473 Based on observation, interview, and record review, the provider failed to maintain the electronic medical record in a readily accessible and systematically organized manner for 10 of 11	F 514	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE Immediate action(s) taken for the resident(s) found to have been affected include: The Director of Nursing Services created a paper copy of resident care plans on 7/23/14 and made it available to all care giving staff. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected.	8/20/14	

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NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045	
(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 514	<p>Continued From page 34 sampled residents (1, 2, 3, 4, 5, 6, 7, 8, 9, and 10). Findings include:</p> <p>1. Observation and review of hard copy chart backs identified with resident name and location revealed documentation the provider had initiated the electronic medical record keeping about a year ago. *The nature of the information maintained on the chart backs was outside source documents such as laboratory test results, physician dictated history and physicals for residents, and copies of durable power of attorney determination for residents. *There was no copy of current resident care plans on the chart backs. *Shortly after the initial tour of the facility each member of the health survey team was provided with a user name and password. *The health survey team was able to access the resident electronic medical records. Not all staff were able to access and had the capability to print documentation from the records.</p> <p>Surveyor: 32331 2. Interview on 7/22/14 at 3:23 p.m. with certified nursing assistant (CNA) J and with another surveyor regarding accessibility of care plans revealed: *She had "no clue" on how to access the care plans on the kiosks. *There were four kiosks on each wing (100, 200, and 300) and one in the dining room. *She knew how to take care of residents based on input from report and general knowledge of the residents. *She stated the care plans were in the provider's computer and she was unable to access them.</p>	F 514	<p>(Con't from page 35)</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>The Director of Nursing Service and Administrator will provide refresher training to all care giving staff during the inservice scheduled for 8/20/14.</p> <p>Additional training will be provided via the orientation process to new hires to include specific emphasis on how to access the care plan for residents.</p> <p>The 'Orientation Checklist for New Certified Nurse Assistants was updated on 8/18/14 to include 'Access Care Plan on PCC (Kardex Button)'. Both the trainer and CNA is required to initial completion of the task during the training process.</p> <p>The 'M-OCC Orientation Checklist for New Employees (Nurse) was updated on 8/18/14 to include subsection © under 'Documentation' to state the following: "Care Plan Access on PCC (Kardex Button). The trainer is required to initial the document to indicate the training is completed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2014
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045		
(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 514	Continued From page 35 Surveyor: 32355 Interview on 7/22/14 at 3:00 p.m. with CNA K revealed: *He had been hired through a temporary agency to work in the facility as needed. *He had been coming to work at this facility on and off for six months. *He had no access to get into the kiosks for charting or retrieving information from the care plans. *There had been no hard copy of care plans for him to refer to in regards to assisting the residents with care and ensuring their individual needs were met. *He had relied upon the regular staff who worked in the facility to provide him with the necessary information to take care of the residents. *He had been unable to do his own charting on the residents due to the inability to have access into the kiosk. *He had relied on the regular staff to do his charting for him. 3. Interview on 7/24/14 at 11:40 a.m. with the director of nurses revealed she had: *Been aware the care plans could only be accessed and viewed electronically. *Not been aware CNA J had not been educated on the ability to access the care plans on the kiosk to assist her with meeting the residents' needs. *Not been aware that CNA K was not able to access the kiosk to obtain the care plan information and to document his work.	F 514	(Con't from page 36) How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning 8/20/14, the Director of Nursing Services, or designee, will review a sample * of 2/51 of new hire orientation sheets each month to determine that proper training has been completed. * Director of Nursing Services or designee will report results to the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. *Temp worker K was added to the record access and staff J received re-education on the proper way to access care plans in the POC. DW/SDDOH/MF		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
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NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045
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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
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/23/14. Menno-Olivet Care Center (Building 01) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE <i>Kaleb C. Light</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/19/14</i>
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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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
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NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045
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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
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/23/14. Menno-Olivet Care Center (Building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Kaleb Hight

Administrator

8/19/14

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 141 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.

<p>DISCLOSED</p> <p>AUG 21 2014</p> <p>If continuation sheet Page 1 of 1</p> <p>SD DOH L&C</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
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NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045
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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
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/23/14. Menno-Olivet Care Center (Building 03) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kalene C. Light</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/19/14</i>
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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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045
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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) COMPLETE DATE
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S 000	Initial Comments Surveyor: 27473 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/22/14 through 7/24/14, Menno-Olivet Care Center was found not in compliance with the following requirements: S206 and S301.	S 000	Addendums noted with an asterisk per 9/14/14 telephone to facility administrator. DWISDDO/HMF	
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks, and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs.	S 206	44:04:04:05 PERSONNEL-TRAINING Immediate action(s) taken for the resident(s) found to have been affected include: Staff Development Nurse was informed of the need to include dining assistance, nutritional risks and hydration needs to training of new personnel. * Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Employees N, O and P were included in education. DWISDDO/HMF	9/10/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Kalvin C. Light

TITLE

Administrator

STATE FORM

6899

OJ1V11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045
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S 206	<p>Continued From page 1</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32355</p> <p>A. Based on record review, interview, and policy review, the provider failed to ensure three of five sampled newly hired employees (N, O, and P) received all ten of the orientation programs. Findings include:</p> <p>1. Review of certified nurse assistants (CNA) N and P and dietary aide O's training and orientation records revealed they had not received training for: *The proper use of restraints (restricts movement). *Dining assistance, nutritional risks, and hydration needs of the residents.</p> <p>Interview on 7/24/14 at 11:10 a.m. with the director of nursing revealed: *She had not been aware of the above newly hired employees had not received all of the required training during their orientation. *She had been unable to find any further education to support the two above mentioned areas had been addressed during their orientation and training program.</p> <p>Review of the provider's April 2008 Orientation Program for Newly Hired Employees policy revealed all ten of the required orientation programs for the newly hired employees had not been listed.</p> <p>Surveyor: 32331</p> <p>B. Based on record review, interview, and policy review, the provider failed to ensure all employees received training for one of ten mandated annual topics (dining assistance, nutritional risk, and hydration needs of residents).</p>	S 206	<p>(Con't from page 1)</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>All new employees will be trained in dining assistance, nutritional risks and hydration needs of the residents by viewing a video titled, 'Avera Education Mandatory Extravaganza'. Current employees will receive inservice training on dining assistance, nutritional risks and hydration needs on 9/10/14 by a Registered Dietician.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Staff Development Nurse, or designee, will monitor new staff for completion of viewing of required video. Monitoring will continue monthly and results reported to the Quality Assurance Committee.</p> <p>Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p> <p><i>* all in-service topics are completed annually within a 12 month time frame. DW/08/04/14</i></p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045
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S 206	<p>Continued From page 2</p> <p>Findings include:</p> <p>1. Review of the staff in-service records from 6/1/13 through 7/24/14 revealed there had been no staff training on dining assistance, nutritional risk, and hydration needs of residents.</p> <p>Interview on 7/24/14 at 10:10 a.m. with staff Q in human resources confirmed the in-service topic of dining assistance, nutritional risk, and hydration needs of residents had not been conducted for all employees within the annual time frame.</p> <p>Review of the provider's December 2011 In-Service Training Program Annual policy revealed: *All personnel should have participated in regularly scheduled in-service training classes. *All personnel were required to attend regularly scheduled in-service training classes. *The ten mandated annual topics were not listed on the policy.</p>	S 206		
S 301	<p>44:04:07:16 Required dietary in-service training</p> <p>The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing in-service training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.</p>	S 301	<p>44:04:07:16 REQUIRED DIETARY INSERVICE TRAINING</p> <p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>All food handling employees will participate in an in-service training on 9/10/14 to encompass the following topics: Leftover food handling, time and temperature controls for food preparation and service, and nutrition and hydration.</p>	9/10/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045
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S 301	<p>Continued From page 3</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure three of nine required annual in-service training sessions (leftover food handling policies, time and temperature controls for food preparation and service, and nutrition and hydration) were offered for all food-handling staff yearly. Findings include:</p> <p>1. Record review of the required in-service training sessions from 6/1/13 through 7/24/14 for all food handling staff revealed: *Those staff had received no annual training on the following: -Leftover food handling policies. -Time and temperature controls for food preparation and service. -Nutrition and hydration.</p> <p>Interview on 7/23/14 at 2:50 p.m. with the dietary manager and at 4:35 p.m. with the director of nursing regarding required annual in-service training sessions from 6/1/14 through 7/24/14 for all food handlers revealed: *Food handling staff were identified as all staff. *There had not been an in-service on leftover food handling policies, time and temperature controls for food preparation and service, and nutrition and hydration. *They had not known that all food handling staff were to have received that annual in-service training.</p> <p>Review of the provider's December 2011 In-Service Training Program Annual policy revealed: *Annual in-services were to have covered the</p>	S 301	<p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has determined that all residents have the potential to be affected.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>All new employees will be trained in dietary procedure required by law for food handling employees during their initial orientation period. The Staff Development Nurse will ensure that all required inservice topics are covered within a 12 month timeframe annually.</p>	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET POST OFFICE BOX 487 MENNO, SD 57045
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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) COMPLETE DATE
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S 301	Continued From page 4 following topics: -Food safety. -Handwashing. -Handling and preparation techniques. -Food-borne illnesses. -Serving and distribution procedures. -Leftover food handling policies. -Time and temperature controls for food preparation and service. -Nutrition and hydration. -Sanitation requirements. *All personnel were required to attend regularly scheduled in-service training classes.	S 301	<p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Staff Development Nurse, or designee, will monitor new staff for completion of viewing of required video. Monitoring will continue monthly and results reported to the Quality Assurance Committee. The Director of Nursing Services, Dietary Manager, or designee(s), will monitor the yearly inservice schedule to ensure that the appropriate topics are covered within a 12 month timeframe annually. Monitoring will continue monthly and results reported to the Quality Assurance Committee.</p> <p>Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p> <p><i>*Staff Development Nurse will monitor that all employees have required training, and report results to quality Assurance committee. DW/SDDOH/MF</i></p>	
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