

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

ORIGINAL

PRINTED: 11/05/2015
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 10/15/2015
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET 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 000	INITIAL COMMENTS Surveyor: 33488 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from October 13, 2015 through October 15, 2015. Menno-Olivet Care Center was found not in compliance with the following requirements: F272, F332, and F441.	F 000	*Addendums noted with an asterisk per 11/24/15 per telephone with facility DON. NPN/SDDOH/EL	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272	Tag sited: F272 483.20(b)(1) – Comprehensive Assessments 1. Immediate action(s) taken for the resident(s) found to have been affected include: Meeting on 10/16/2015 with Interdisciplinary Team and reviewed resident 6 – determination was found that when residents return from the hospital they should be evaluated by the IDT within 3 days to determine if a significant change/re-admit MDS assessment should be completed. CAA's will then be done if a significant change is determined. 2. Identification of other residents having the potential to be affected was accomplished by:	11/06/15

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

TITLE

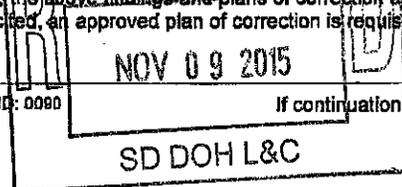
(X8) DATE

Lucie Smith

Administrator

11/05/2015

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

PRINTED: 11/05/2015
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 10/15/2015
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET 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 272	<p>Continued From page 1</p> <p>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on record review, interview, and manual review, the provider failed to have the additional assessments (CAA) recommended by the completion of the Minimum Data Set (MDS) assessment for one of nine sampled residents (6). Findings include:</p> <p>1. Review of resident 6's medical record revealed: *She had a fall on 7/30/15. *She had been admitted to the hospital for a femur fracture (break to the thigh bone) on that day. *She had been readmitted to the facility on 8/4/15. *The 8/11/15 MDS assessment revealed: -It had been coded as a five day scheduled assessment for Medicare Part A stay. -She had received 289 minutes of occupational therapy. -She had received 223 minutes of physical therapy. -There had not been any documentation the</p>	F 272	<p>All residents re-admitted to the facility following a hospital stay have the potential to be affected by this practice.</p> <p>3. Action(s) taken/systems put into place to reduce the risk of future occurrence include:</p> <p>Director of Nursing, MDS Coordinator, Social Service Coordinator, Dietary Manager & Facility Administrator spoke via phone conference with [REDACTED] *Medicare Nurse NPN/SDDOH/EL Consultant on 11/3/2015 related to re-admits to facility and when CAA's should be completed. Covered Significant Change in Status Assessment and what constitutes a significant change.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p>		

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

PRINTED: 11/05/2015
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 10/15/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET 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 272	<p>Continued From page 2 CAAs had been completed.</p> <p>Interview on 10/14/15 at 11:10 a.m. with the MDS registered nurse regarding resident 6 revealed: *She had started as the MDS coordinator on 9/1/15. *She had not completed the resident's 8/11/15 MDS assessment. *She thought the CAAs including the 8/11/15 should have been completed.</p> <p>Interview on 10/14/15 at 2:10 p.m. with the director of nursing (DON) revealed: *The DON had been the MDS coordinator from January 2015 through August 2015. *The DON had not done the 8/14/15 CAAs for resident 6. *The DON had done CAAs for other resident admissions and annual assessments. *The DON confirmed: -Resident 6 had not been on skilled nursing services prior to returning on 8/4/15 but was readmitted on skilled nursing. -The 8/11/15 CAAs should have been completed for resident 6. *She went by the Resident Assessment Instrument (RAI) User's Manual when completing the MDS.</p> <p>Review of the Resident Assessment Instrument User's Manual, (V1, 12), Chapter 4: CAA Process and Care Planning, page 4-2 revealed: **The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments. *It also provides a basis for additional assessment of potential issues, including related risk factors.</p>	F 272	<p>Director of Nursing/Nurse Coordinator will monitor to ensure that CAA's are completed appropriately.*1</p> <p>[REDACTED]</p> <p>Then, monitoring for CAA completion will be done monthly.</p> <p>Audit results will be reviewed by the QAPI Team until such time consistent, substantial compliance has been achieved as determined by the committee.</p> <p>Corrective action completion date: 11/6/2015.</p> <p>*Monitoring for all significant changes, admit or re-admit CAA completion will be done once per week by the DON/Nurse coordinator for (3) three months. NPN/SDDOtt/EL</p>	
-------	---	-------	--	--

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

PRINTED: 11/05/2015
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 10/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET 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 272	Continued From page 3 *The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care."	F 272		
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, drug reference review, and policy review the provider failed to ensure 2 of 25 medication observations were administered appropriately during two of twenty-six medication observations to residents (11 and 12) for an error rate of 8 percent (%). Findings include:</p> <p>1. Observation on 10/13/15 at 5:15 p.m. of medication aide A administering medication to resident 11 revealed: *The resident was to receive tamsulosin (used to increase urinary flow). *Medication aide A opened the medication capsule and poured the contents into a medication cup and mixed it with applesauce. *She proceeded to administer the medication to the resident.</p> <p>Review of the provider's Lippincotts 2011 Nursing Drug Guide available to all nursing/medication aide staff revealed that medication was not to be opened, crushed, or chewed.</p>	F 332	<p>1. Immediate action(s) taken for the resident(s) found to have been affected include: New and updated DO NOT CRUSH list printed and placed on medication cart and medication aides informed where to find it. *1 → See page 4 A out of 10</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: All residents with a crush order receiving crushed medications or capsules that can be opened have the potential to be affected by this practice.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nurses and medication aides were in-serviced on preventing medication errors on 11/4/2015 by the Director of Nursing. The Director of Nursing audited all nurses/medication aides passing medications individually from 11/2/2015 – 11/5/2015.</p>	11/06/15

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

PRINTED: 11/05/2015
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 10/15/2015
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET MENNO, SD 57045 4A	
(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 272	Continued From page 3 *The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care."	F 272	*Resident 11's physician was notified of certified med aide A opening capsule and Tamsulosin was discontinued. No other medication was begun in its place. Resident 12's physician was notified that Isorbide Mononitrate ER was crushed by CNA A, Resident 12 was on hospice and all oral blood pressure medications were discontinued 11/6/15 due to inability to swallow medications. NPN/SDDOHH/EL	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, drug reference review, and policy review the provider failed to ensure 2 of 25 medication observations were administered appropriately during two of twenty-six medication observations to residents (11 and 12) for an error rate of 8 percent (%). Findings include: 1. Observation on 10/13/15 at 5:15 p.m. of medication aide A administering medication to resident 11 revealed: *The resident was to receive tamsulosin (used to increase urinary flow). *Medication aide A opened the medication capsule and poured the contents into a medication cup and mixed it with applesauce. *She proceeded to administer the medication to the resident. Review of the provider's Lippincotts 2011 Nursing Drug Guide available to all nursing/medication aide staff revealed that medication was not to be opened, crushed, or chewed.	F 332		

4A of 10

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

PRINTED: 11/05/2015
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 10/15/2015
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET 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 332	Continued From page 5 before administration. *The list was not to have been an all inclusive list. *It had not included the above medications. Interview and record review on 10/15/15 at 9:15 a.m. with the director of nursing (DON) regarding the above medication administrations revealed: *The above medication policy was quite old, and needed to be updated. *The above medications were not on the list. *She agreed the above medications should not have been crushed or opened. *It was her expectation staff would look to see if a medication could be crushed or opened according to manufacturer's guidelines.	F 332	Audit results will be reviewed by the QAPI Team until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 11/6/2015.	*MONTHLY NPN/BOBOK/EL
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 actions related to infections. (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	F 441	Tag sited: F441 483.65 Infection Control, Prevent Spread, Linens 1. Immediate action(s) taken for the resident(s) found to have been affected include: A bottle of Sani-cloth disinfecting wipes was placed on the treatment cart and a bag of disposable chucks was placed in bottom drawer of treatment cart to be used during dressing changes. 2. Identification of other residents having the potential to be affected was accomplished by:	11/06/15

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

PRINTED: 11/05/2015
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 10/15/2015
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET 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 6 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: 33488 Based on observation, interview, and policy review, the provider failed to ensure appropriate infection control technique had been followed during one of one observed dressing changes for resident (2). Findings include:</p> <p>1. Observation on 10/14/15 at 9:10 a.m. with registered nurse (RN) B providing a dressing change and medication administration to the resident revealed: *While she washed her hands, the resident laid down in bed and had propped his bare foot up on the bedside table. *On the other side of that table she placed paper towels to create a clean barrier for the following supplies she planned to use: -An insulin syringe filled with his insulin dose. -Prescription gel. -A scissors and various bandages.</p>	F 441	<p>All residents receiving wound care/dressing changes have the potential to be affected by this practice.</p> <p>3. Action(s) taken/systems put into place to reduce the risk of future occurrences include: A mandatory in-service conducted for nurses on 11/4/2015 to cover: Handwashing, Wound/Dressing Changes, Linen Pass, Disinfecting Equipment & Proper Labeling & Handling of Clean/Dirty Equipment.</p> <p>Over the next 2 weeks, Director of Nursing /Nurse Educator will work with each nurse individually to ensure they can return demonstrate what was learned in the in-service.</p> <p>4. How the action(s) will be monitored to ensure the practice will not recur: Director of Nursing/Nurse Coordinator/Nurse Educator will monitor one wound/dressing change weekly for three months. Then, random wound/dressing change monitoring will be done monthly. *for one year. NPN/SDDOHT/EL</p>		

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

PRINTED: 11/05/2015
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 10/15/2015
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET 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 7 *She proceeded to sit on a chair at a distance from the resident and removed the old dressing and performed the dressing change *She was unable to easily reach the necessary dressings/supplies on the far side of the bedside table from where she sat. *She had not removed the residents personal items (Kleenex, TV remote, etc) from the bedside table prior to placing her dressing change and insulin supplies on it. *During the dressing change she: -Dropped the scissors, plastic bag of dressings, and tape on the floor. -Picked up the scissors off the floor with her bare hands after removing her gloves. *The resident then moved his leg and rested his foot on the bed. *She set the dirty scissors on the bedside table where the resident had rested his bare foot. *She then moved the soiled scissors again with her bare hands farther over on the table back to the clean barrier area, picked up the insulin vial with her bare hand and set it on the dirty area where she just removed the scissors from. *She proceeded to re-wash her hands, put on gloves, pick up the insulin syringe and administer it to the resident. *An unidentified hospitality aide delivered drink to the resident at that time. *When asked where the aide should place the juice RN B motioned for her to set it on the bedside table where the soiled scissors and resident's bare foot had been. *While attempting to reach her supplies the paper tape rolled off the bedside table and across onto the bathroom floor threshold. *She asked this surveyor to hand her the paper tape. *She continued to use that paper tape and she	F 441	Audit results will be reviewed by the QAPI Team until such time as consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 11/6/2015.	

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

PRINTED: 11/05/2015
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 10/15/2015
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET 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 8</p> <p>secured the dressings and elastic bandages to the resident's leg.</p> <p>*Once the task was completed she removed her gloves and washed her hands.</p> <p>*She picked up the soiled scissors and plastic bag that contained the dressings and paper tape.</p> <p>*She carried those items into the hallway and set them on the top of her medication/treatment cart, and stated she would sanitize them later.</p> <p>*She had not re-sanitized her hands or washed them after touching the soiled items.</p> <p>*The resident had been known to set his urinal (container holding urine) on the bedside table at night for ease of use.</p> <p>*She had not cleaned or disinfected the surface of the table prior to or after the dressing change.</p> <p>Interview on 10/15/16 at 9:20 a.m. with RN B regarding the above dressing change revealed she agreed:</p> <ul style="list-style-type: none"> -She should not have touched soiled items with her bare hands. -Should have cleaned the bedside table prior to putting a clean barrier down and to remove unnecessary personal items from obstructing her reach. -Should have disposed of the soiled dressings and not taken them out of the room or set them on her medication/treatment cart. <p>Interview on 10/15/17 at 9:15 a.m. with the director of nursing regarding the above dressing change revealed it was her expectation appropriate infection control measures were to be followed at all times.</p> <p>Review of the provider's 2014 Clean Dressing Change policy revealed:</p> <p>*If the bedside table was soiled, it was to be</p>	F 441			

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

PRINTED: 11/05/2015
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 10/15/2015
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET 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 9 wiped with a clean towel. *No mention of using any appropriate disinfecting or sanitizing solution to have been used with the clean towel. *Only the supplies for the dressing change were to be placed on the clean field. *No mention of using or disinfecting soiled re-use items such as soiled scissors.</p> <p>Review of the provider's 2014 Infection Control policy revealed: *The purpose was to prevent the spread of infection. *Re-useable items potentially contaminated should have been placed in a clear plastic bag labeled contaminated and placed in a soiled utility room for pickup and processing.</p>	F 441			

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

ORIGINAL

PRINTED: 11/30/2015
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 03 - BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED 10/14/2015
--	---	--	---

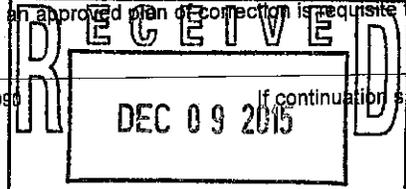
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET MENNO, SD 57045
---	---

(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
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/14/15. 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		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Leslie Smith</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/09/15</i>
--	-----------------------------------	----------------------------------

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

ORIGINAL

PRINTED: 11/30/2015
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 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 10/14/2015
--	---	--	---

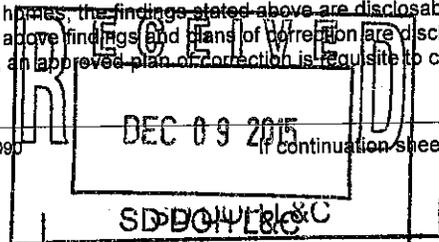
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET MENNO, SD 57045
---	---

(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
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/14/15. 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		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Leslie Smith</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/07/15</i>
--	-----------------------------------	----------------------------------

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

ORIGINAL

PRINTED: 11/30/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/14/2015
--	---	--	---

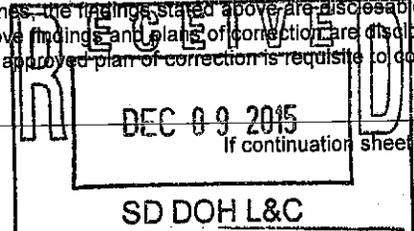
NAME OF PROVIDER OR SUPPLIER MENNO-OLIVET CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 S PINE STREET MENNO, SD 57045
---	---

(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
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/14/15. 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		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Aedie Smith</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/04/15</i>
---	-----------------------------------	----------------------------------

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.



ORIGINAL ORIGINAL

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 10/15/2015
--	--	---	---

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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 10/13/15 through 10/15/15. Menno-Olivet Care Center was found not in compliance with the following requirement: S210.	S 000	*Addendums noted with asterisk per 11/24/15 per telephone with facility DOK Tag Cited: S210 NPN/SDDOH/EL Employee Health Program	11/05/15
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 29354 Based on record review, interview, and policy review, the provider failed to ensure five of five sampled employees (A, C, D, E, and F) had a health evaluation completed within fourteen days	S 210	1. Immediate action(s) taken for the resident(s)/new hire(s) found to have been affected include: Contacted temp agencies & requested immunization records & a signed statement by a healthcare professional that the individual coming to work is free of communicable diseases 2. Identification of other new hire/employees having the potential to be affected was accomplished by: All new hires and new admissions have the potential to be affected by this practice. 3. Action(s) taken/systems put into place to reduce the risk of future occurrences include: Freeman Rural Medical Clinic contacted via e-mail on 11/2/2015 to provide pre-employment physicals at the Menno Clinic. Infection Control policy updated on 11/3/2015.	

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

Ledie Smith

TITLE

Administrator

(X6) DATE

11/05/15

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 10/15/2015
--	--	---	---

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) COMPLETE DATE
S 210	<p>Continued From page 1 of being hired. Findings include:</p> <p>1. Review of the following employees personnel records revealed the following hired dates: *Employee A 9/1/15. *Employee C 8/31/15. *Employee D 8/4/15. *Employee E 5/11/15. *Employee F 8/18/15. *There was no documentation in the above employees personnel files a health evaluation had been reviewed and signed by a health care professional to determine the employees were free of communicable diseases.</p> <p>Interview on 10/14/15 at 3:15 p.m. with the director of nursing revealed: *She confirmed there was no documentation in employee A, C, D, E, and F's personnel files a health evaluation had been completed within fourteen days of being hired to determine they were free of communicable diseases. *She was not aware it needed to be done.</p> <p>Review of the provider's 2010 Employee Health General Information and Orientation (Related to Infection Control Orientation) policy revealed "All new employees will be assessed for signs and symptoms of active communicable diseases upon employment. If any problem is suspected, the employee will be referred to their physician for full evaluation prior to beginning or resuming work."</p>	S 210	<p>Updated Infection & Communicable Disease History form for residents/new hires to include signature & date from a healthcare professional. Infection & Communicable Disease History form put in admission pack and in new hire pack.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>Infection Control Nurse & Human Resources will monitor to ensure the Infection & Communicable Disease History form is completed & signed by a healthcare professional before a new hire begins work or a new resident is admitted to the facility.</p> <p>Weekly audits will be done for 3 months by Infection Control Nurse/Human Resources. Then, audits will be done monthly. <i>*for one year, NPN/SPD/OTIE</i></p> <p>Audit results will be reviewed by the QAPI Team until such time as consistent substantial compliance has been achieved as determined by the committee.</p> <p>Corrective action completion date: 11/6/2015.</p>	