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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING ______ B. WING ______	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	**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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/24/23 through 7/27/23. Menno-Olivet Care Center was found not in compliance with the following requirement: F880.	F 000	F 880 Action Items 1. The administrator, DON/Infection Preventionist, and housekeeping supervisor in consultation with the medical director will review and revise the Cleaning and Disinfection of Environmental Surfaces policy to decrease the chance of cross-contamination between resident rooms.	9/8/23
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880	2. In-service training is to be completed with housekeeping supervisor, DON/Infection Preventionist, and Administrator by Hillyard Representative upon installation of new system. In-service training will be led by housekeeping supervisor, DON/ Infection Preventionist, and administrator to all housekeeping staff, all laundry staff, and all nursing staff. Education will include the proper use of cleaning solution(s), and changing of mop heads per facility policy. Ongoing education will be provided upon any revision of this policy by the DON/Infection Preventionist, or designee. Education will also include the need for best practice in infection control to avoid any cross-contamination. 3. System change is necessary at our facility to improve best infection control practices. Cross-contamination was found to be at an increased risk because of our mop and bucket system. Our facility	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Kettwig
TITLE: Administrator
(X6) DATE: 08/21/2023

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.

RECEIVED AUG 23 2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING ______ B. WING ______	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	**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 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to prevent potential	F 880	increased the risk for infection by using this same mop water in resident rooms, bathrooms, and hallways while using the same mop heads. With this concern, the Administrator contacted the South Dakota Quality Improvement Organization on 8/14/23. The main contact person(s) were in meetings so administrator had a conversation and discussion with QI Advisor. QI Advisor was in agreement with this facility's plan of correction and change of policy to avoid risk of cross-contamination among resident rooms and facility. QI Advisor gave contact information to administrator and offered additional assistance/information via email. 4. Housekeeping and DON/Infection Preventionist will audit the proper use of mopping solution and the changing of the mop heads twice a week for eight weeks, weekly for eight weeks, and monthly for eight months. All data will be reported to QAPI. Audits and re-education will be done by housekeeping supervisor, DON/Infection Preventionist, administrator and/or Hillyard representative if compliance is not met and it will be at the discretion of the housekeeping supervisor and DON/Infection Preventionist for additional audits. Per discussion on 8/14/23, it has been agreed upon that the Hillyard Representative will remain in communication going forward with DON/Infection Preventionist to ensure successful training and proper procedure techniques for staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING ____ B. WING ____	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	**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 880	Continued From page 2	F 880		

cross-contamination and follow their policy for cleaning and disinfection during floor care during one of one randomly observed resident 21's room cleaning by housekeeper M. Findings include:

1. Observation and interview on 7/26/23 at 9:05 a.m. with housekeeper M who was cleaning a randomly observed resident 21's room revealed:
*There was a mop bucket with water and a mop in it outside a resident's room.
*The housekeeper mopped the resident's room and bathroom with the same mop and mop water from the hallway.
*She reported they changed the mop water between every four residents' rooms/bathrooms.
*She used the same mop head for all her floor cleaning for the day throughout the facility.
*At the end of the day she took off the mop head and placed it in the soiled laundry room and it was laundered in the washing machine.
*The floor cleaner product they used was Hillyard's Super Shine-All.
-The product was mixed with water in the mop bucket, and they used a mop to clean the floors.
*She had worked in housekeeping for five years and had received her training from housekeeper N, who came into the resident's room during the interview and was assisting with the room cleaning and dusting.
*Housekeeper N confirmed they used the same mop and mop water from the hallway, changed the mop water between every four residents' rooms/bathrooms, and used the same mop head for all the floor cleaning for the day throughout the facility.

Review of the Hillyard's Super Shine-All manufacturer's product description and instructions for use revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING ______ B. WING ______	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	**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 880	Continued From page 3	F 880		

Continued From page 3

*It's protective sheen helped preserve and protect floors.
*It was an excellent choice for damp mopping.
*The neutral pH would not harm the floor finish.
*There was no mention of it being a disinfectant.

Interview on 7/27/23 at 9:07 a.m. with administrator/emergency permit holder A and director of nursing/infection preventionist B regarding the process for environmental floor cleaning and disinfecting revealed:
*They had followed up with their Hillyard representative and he had confirmed the Super Shine-All floor cleaner was not a disinfectant product.
*They had not been aware that the Super Shine-All floor cleaner was not a disinfectant product and that was the product the Hillyard representative had recommended staff to use throughout the facility.
*They were aware housekeepers used the same mop water for four residents' rooms/bathrooms but had not realized they used the same mop head to clean floors for the entire day.
*Their expectation was the housekeeping staff follow the provider's Cleaning and Disinfection policy and maintain infection control.
*They agreed using the same mop water and mop head in several residents' rooms and bathrooms would be a concern for cross contamination to other areas in the facility.
*They agreed the current floor care process was not consistent with the facility's Cleaning and Disinfection of Environmental Surfaces policy and it had not ensured proper disinfection was occurring throughout the facility.
*They confirmed their processes for not using a disinfectant and not following their policy related

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING ______ B. WING ______	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	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 880	Continued From page 4 to cleaning floors created an infection control risk to the residents. *They agreed they should have ensured their floor cleaning practices were in accordance with their policy. Review of the provider's August 2019 Cleaning and Disinfection of Environmental Surfaces policy revealed: *"c. Non-critical items are those that come in contact with the intact skin but not mucous membranes. (1) Non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture, and floors." "2. Non-critical surfaces will be disinfected with an EPA-registered intermediate or low-level hospital disinfectant according to the label's safety precautions and use directions." "12. Disinfection (or detergent) solutions will be prepared as needed and replaced with fresh solution frequently (e.g., floor mopping solution will be replaced every three resident rooms or changed no less often than at 60-minute intervals). 13. Mop heads and cleaning cloths will be decontaminated regularly (e.g., laundered and dried at least daily)."	F 880		

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

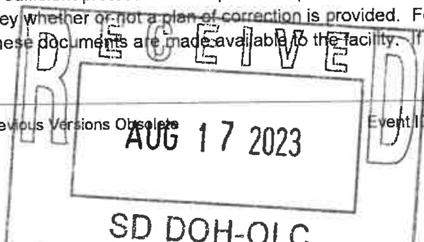
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING ______ B. WING ______	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	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
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 7/24/23 through 7/27/23. Menno-Olivet Care Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Kettwig	Administrator	08/14/2023

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.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	**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	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/25/23. Menno-Olivet Care Center Building 1 was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K226 and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 226 SS=E	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the fire-resistive design of one building separation wall (between the Building 1 and Building 3). Findings include: 1. Observation on 7/25/23 at 11:45 a.m. revealed the two-hour, fire-rated separation wall between the nursing home original building and the nursing home addition had a twelve inch by sixteen inch portion of the two-hour separation	K 226	K 226 Action Items In order to maintain the fire-resistive design of one building separation wall between building 1 and building 3, the maintenance director will put a seal separation between the fire doors by using two pieces of 1/2" sheetrock from both sides and it will be sealed with fire caulk. This will be reported to QAPI upon completion of project.	8/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Kettwig
TITLE: Administrator
(X6) DATE: 08/14/23

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.

RECEIVED
AUG 17 2023
SD DOH-OLC

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	**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 226	Continued From page 1 which had been removed above the lay-in ceiling. The opening must be repaired so that a fire resistant, two-hour wall is maintained. Interview with maintenance staff at the time of the observation confirmed that finding. The deficiency could affect 100% of the occupants of the smoke compartments.	K 226		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K 923	K 923 Action Items Gas equipment will be moved to another location in the facility that will be an enclosed interior space that will not be stored with flammables. This door will be securely locked and will be available for immediate use in patient care areas. A dedicated sign will be placed on the door and gas equipment will be moved by 8/31/23. Education will be provided to staff on 8/31/23 and will be provided by DON and maintenance director. This will be reported to QAPI upon completion of project.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**07/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	**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 923	Continued From page 2 STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to protect medical gas storage as required. Combustible items were stored on racks within five feet of the oxygen cylinders in the spa room being used for oxygen cylinder storage. Findings include: 1. Observation on 7/25/23 at 1:00 p.m. revealed combustible materials were found to be stored above and within five feet of oxygen cylinders in the spa room being used for oxygen cylinder storage. The minimum five feet of separation between combustibles and oxygen storage was not maintained as required in this area. The deficiency affected one of three smoke compartments.	K 923		

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

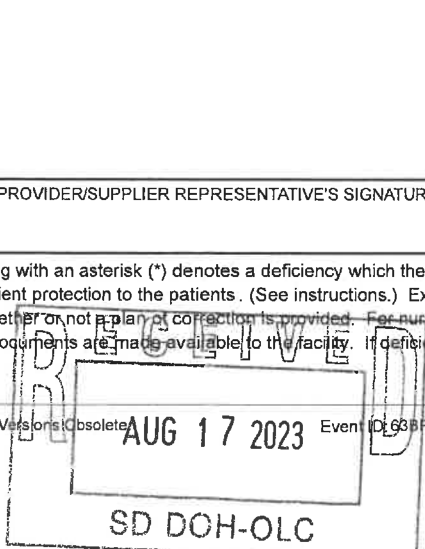
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING **02 - BUILDING 02** B. WING ______	**07/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	**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	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/25/23. Menno-Olivet Care Center Building 2 was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Kettwig	Administrator	08/14/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

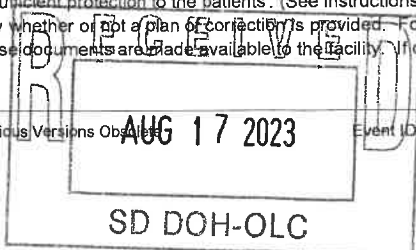
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING **03 - BUILDING 03** B. WING ______	**07/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	**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	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/25/23. Menno-Olivet Care Center Building 3 was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K223 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain three observed hazardous areas (room 304, room 306, and the unnumbered room adjacent to the MDS coordinator office) as	K 223	K 223 Action Items The maintenance director will install self-closing devices on rooms 304, 306, and the unnumbered room adjacent to the MDS coordinator office. Once project is completed, it will be reported to QAPI by the maintenance director.	9/6/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Kettwig	Administrator	08/14/2023

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.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING **03 - BUILDING 03** B. WING ______	**07/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	**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 223	Continued From page 1 required. Findings include: 1. Observation on 7/25/23 at 10:15 a.m. revealed room 304, previously used as a resident room, was over 100 square feet and had large amounts of combustible items stored in it. The corridor door from that room did not have a closer as required. 2. Observation on 7/25/23 at 10:18 a.m. revealed room 306, previously used as a resident room, was over 100 square feet and had large amounts of combustible items stored in it. The corridor door from that room did not have a closer as required. 3. Observation on 7/25/23 at 10:45 a.m. revealed the unnumbered room adjacent to the MDS coordinator office, previously used as a resident room, was over 100 square feet and had large amounts of combustible items stored in it. The corridor door from that room did not have a closer as required. Interview with maintenance staff at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of that smoke compartment.	K 223		

PRINTED: 08/08/2023
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10648	A. BUILDING: ______ B. WING ______	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNO-OLIVET CARE CENTER	**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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/24/23 through 7/27/23. Menno-Olivet Care Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/24/23 through 7/27/23. Menno-Olivet Care Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Kettwig	Administrator	08/14/2023

STATE FORM 6899 V5J611 If continuation sheet 1 of 1