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 _____	05/12/2022

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 partial extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 5/10/22 through 5/12/22. Menno-Olivet Care Center was found not in compliance with the following requirements: F609, F689, F761, F880, and F909. On 5/10/22 at 4:48 p.m. immediate jeopardy was identified related to accident hazard/safety at F689. On 5/10/22 at 6:54 p.m. interim administrator A and director of nursing B were given verbal notice of the immediate jeopardy and were provided with written notice and the immediate jeopardy removal plan template. On 5/11/22 at 10: 51 a.m. the provider's immediate jeopardy removal plan was accepted. On 5/11/22 at 12:45 p.m. during onsite revisit the removal plan was verified and immediate jeopardy removed. On 5/10/22 at 4:48 p.m. immediate jeopardy was identified related contact precaution/infection control at F880. On 5/10/22 at 6:57 p.m. interim administrator A and director of nursing B were given verbal notice of immediate jeopardy and were provided with written notice and the immediate jeopardy removal plan template. On 5/11/22 at 10:51 a.m. the provider's immediate jeopardy removal plan was accepted. On 5/11/22 at 12:45 p.m. during onsite revisit the removal plan was verified and immediate jeopardy was removed.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lacee Feltman, MSN, LNHA
TITLE: Interim Administrator
(X6) DATE: 6/1/22

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

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F 000	Continued From page 1 The resident census was 27.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the South Dakota Department of Health (SD DOH) had been notified of an incident that	F 609	Reporting of accidents policy has been updated. RN on duty at time of any accident requiring first aid will fill out initial state report and DON or designee will be responsible for completing state report after completing internal investigation. Procedure for internal investigation updated to include obtaining written witness statements from those with information regarding incident. DON will maintain internal investigations. Staff educated on this change to policy and procedure during staff meeting on June 7th. DON will audit all accidents for the next three months to ensure they are appropriately investigated and reported. DON will bring results of audit to QAPI monthly for review and recommendation.	6-7-22

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F 609	Continued From page 2	F 609		

caused physical harm one of one sampled resident (18). Findings include:

1. Review of medical record of resident 18's chart revealed documentation made by unknown author.
*On 3/19/22 at 8:30 a.m. the resident had requested broth because her stomach had been not feeling "quite right".
*The record reflected she "had the cup between her legs and as she grabbed the it to take a drink, it slipped from her grip and spilled on her right thigh."
*She immediately used her call light.
*Upon assessment of the area, a large red area and two blistered open areas had formed.
*The burn measured 12 centimeters (cm) by 29 cm.
*Within the affected area three spots had skin peeled away.
*One area had been unmeasureable.
*Two areas lateral thigh measured:
-1 cm by 0.8 cm and the other 3 cm by 2 cm.

Interview on 5/10/22 at 4:30 p.m. with Interim administrator A and director of nursing B regarding incident revealed:
*It had not been reported to the SD DOH.
*They had not felt that it needed to be reported.

Review of provider's October 2012 policy for Accident and Incidents-Investigating and Reporting revealed:
*The nurse supervisor/charge nurse and/or department director of supervisor would have a Report of Incident/Accident form and submitted the original to the director of nursing within 24 hours of the incident or accident.
*The director of nursing would ensure that the

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F 609	Continued From page 3 administrator received a copy of the form for each occurrence. *Policy had not identified reportable incidents or accidents. *Request made to director of nursing B for a copy of the report of incident/accident pertaining to this incident. -No copy of the report had been received during the survey.	F 609	All foods and hot beverages are temped prior to being served. Policy was created to not serve any hot beverages or foods over the temp of 150 degrees. Dietary staff were educated on new policy and procedure on 5/11/22. All residents were assessed for safety with hot beverages as well as independent eating on 5/11/22 and will continue to be assessed on a quarterly basis. Policy reviewed and staff education provided during 6/7/22 staff meeting. The dietary manager or designee is auditing food service temps for all room trays five times a week for four weeks then three times a week for four weeks then once a week ongoing. Dietary manager or designee will also audit food temps in dining room five times a week for four weeks then three times a week for four weeks then once a week ongoing. Results of audits will be brought to QAPI monthly for review and recommendations.	6/7/22
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the provider failed to ensure: *One of one sampled resident (18) was free from serious injury after being served hot liquids that resulted in severe burns with blistering and open wounds. *Assessments had been completed to ensure one of one sampled resident (18) was appropriate to consume hot liquids. *They had a policy in place to prevent serious injuries from hot liquids. *Preventative measures including monitoring of liquid temperatures prior to serving one of one sampled resident (18)'s serious injuries. * Findings include:	F 689		

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F 689	Continued From page 4 On 5/10/22 at 4:48 p.m. an immediate jeopardy had been identified related to accident/hazard F689. Notice: Notice of immediate jeopardy was given verbally on 5/10/22 at 6:54 p.m. to interim administer A and director of nursing B. *On 5/10/22 at 4:48 p.m. an immediate jeopardy had been determined when the facility failed to ensure: *Liquids were served at a safe temperature. *Resident had been assessed for hot beverage safety. *Safe eating practices relating to hot liquids. On 5/10/22 at 6:54 p.m. interim administrator A, director of nursing B were asked for an immediate removal plan. Plan: On 5/11/22 at 10:51 a.m. the provider's immediate jeopardy plan was accepted. The facility provided the following acceptable removal plan on 5/11/22 at 10:51 a.m.: 1. Hot liquid safety policy created. All residents will be assessed tonight. Policy is attached and includes that all residents will be assessed on admission, quarterly and with any sig change. Policy also includes that no beverages, soups or hot cereals will be served over 150 degrees. I have already called the dietary manager and the cook that will be doing breakfast tomorrow and informed them of this. 2. Unsupervised feeding safety assessment has been created. This will be done on admission, quarterly and with any sig change. These will be	F 689		

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F 689	Continued From page 5	F 689		

started tonight and finished in the morning to fully assess functional status while residents are eating.
All staff will receive training on these two new policies. Nurses will receive training on the assessments. This training will be started tonight and be completed tomorrow. Staff will not be allowed to work after 5/11 at 0900 until they have read these two new policies and signed that they have received the education. Education will be provided during shift change for nursing department and by dietary manager in the morning upon the arrival of dietary staff.
Dietary manager or designee will audit food temps for all room trays five times a week for four weeks then three times a week for four weeks then once a week for four weeks. Dietary manager or designee will also audit food temps in dining room five times a week for four weeks then three times a week for four weeks then once a week for four weeks.

The immediate jeopardy had been removed on 5/11/22 at 12:45 p.m. during onsite revisit after verification the provider had implemented their removal plan. After removal of Immediate Jeopardy the scope and severity of this citation is level "G".

1. Observation and interview on 5/10/22 at 9:30 a.m. with resident 18 revealed she:
*Had been sitting with the head of bed elevated.
*Had lived in the facility since 6/20/10.
*Had worn oxygen at 2-3 liters per nasal cannula, would fall asleep frequently during the interview, but would awoke with verbal stimuli.

Record review of resident 18's electronic medical

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F 689	Continued From page 6 record revealed she: *Had a brief interview for mental status score of 15. -Indicating cognitively intact. *Had a history of diabetes. *On 3/19/22 at 8:30 a.m. she had received a room tray with broth. *She had lost her grip on the cup of broth and burned her right thigh. *Had been received daily and as needed dressing changes to the affected area. *Initial wound size had measured 12 centimeters (cm) by 29 cm. -"Open areas" noted to wound. *On 3/25/22 resident developed shivering and was not feeling quite right. *On 3/25/22 resident had been transferred to hospital. -Had been hospitalized for elevated white count related to burn and aspiration pneumonia. *On 3/31/22 resident had been returned from the hospital to the facility. Interview with dietary manager D on 5/10/22 at 3:43 p.m. regarding temperatures of beverages served revealed: *She had taken any temperatures of hot liquids before serving them to the residents. *She had started taking temperatures after resident 18 returned from her hospital stay on 3/31/22. Interview on 5/10/22 at 4:30 p.m. with interim administrator A and director of nursing B regarding the above revealed: *They had not assessed the resident for hot liquids safety. *Did not have a policy related to safe liquid temperature to be served.	F 689		

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F 689	Continued From page 7 *Agreed that hot liquids had not had temperatures obtained prior to being served to the residents.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure full Sharps containers were stored in a secured manner when awaiting pick-up for destruction in one of one soiled utility room. Findings include:	F 761	A lock was on a cabinet in the soiled utility room on 6/1/22. The sharps container collection box has been in this locked cabinet. The nurse will have a key to this lock on the nurses key ring and a copy will be maintained by the DON. Policy updated to include storage of full sharps containers will be in a locked cabinet in the soiled utility room with keys maintained by DON and on the nurses key ring. Nurses educated on this change from DON 6/1/2022-6/4/2022 via 1:1 discussion and policy review. DON or designee will audit that cabinet is locked and that sharps container is secured within the cabinet weekly for four weeks and then monthly ongoing. Results of audit will be brought to QAPI monthly for review and recommendation.	6-7-22

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F 761	Continued From page 8 1. Observation on 5/10/22 at 1:50 p.m. of the soiled utility room revealed: *The soiled utility room had a key code lock. *A large cardboard box containing a red medical waste bag with two Sharps containers sat on the floor beside the sink. -Both containers were full of syringes. -One container held an open vial. --This surveyor was not able to see the contents or label of the vial. *Several employees entered and exited the room during the observation. Observation on 5/11/22 at 1:50 p.m. of the soiled utility room revealed: *The door was slightly open and unlocked allowing the surveyor to enter without assistance. *The box containing the Sharps containers remained unsecured on the floor. Interview at that time with housekeeper G regarding the door lock and access by staff or residents revealed: *All employees had the key code to enter the room. *All staff knew how to enter the locked utility room if the eyewash station in the room needed to be used. *When asked if the housekeepers were responsible for handling the Sharps containers housekeeper G stated they did not. Observation on 5/12/22 at 8:35 a.m. of the soiled utility room revealed the door was slightly opened and unlocked. No employees were in the room. Interview on 5/12/22 at 10:32 a.m. with director of nursing (DON) B regarding the security of the Sharps containers confirmed:	F 761		

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F 761	Continued From page 9 *Staff kept the Sharps containers in the soiled utility room. *The provider's waste management company came monthly to remove the medical waste. *All staff had the key code to access the soiled utility room. *She: -Sometimes placed used medication vials into the Sharps containers. -Said they do not put pills into the Sharps containers. *The medical waste waiting for removal should have been in a location where staff access was limited. Review of the provider's February 2019 policy for Sharps Disposal had not indicated: *Directions for secure storage of Sharps containers. *What should or should not be placed in the Sharps containers.	F 761		
F 880 SS=J	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:	F 880		

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F 880	Continued From page 10 §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 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	F 880	Directed Plan of Correction Menno-Olivet Care Center F880 Corrective Action: 1. For the identification of lack of *Appropriate contact precautions initiated for resident identified with MRSA. [Do continue with plan identified for removal of immediate jeopardy, review and provide additional education for all staff. *Appropriate care and dressing change technique. *Appropriate procedural technique for cleaning and disinfecting whirlpool tub between residents and considered use for resident with MRSA. The administrator, DON, and/or designee in consultation with the medical director will review, revise create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by June 7th, 22 by Director of Nursing.	

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F 880	Continued From page 11 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: A. Based on observation, interview, and record review the provider failed to ensure resident 18 had been placed on contact precautions as a result of a diagnosis of Methacillin-Resistant Staph Aureus (MRSA). Findings include: *One of one sampled resident (18) had open wounds and had been receiving daily dressing changes. *Endanger all residents with potential of cross contamination related to no contact precautions. On 5/10/22 at 4:48 p.m. immediate jeopardy had been identified related infection control/contact precautions F880. Notice: Notice on 5/10/22 at 6:57 p.m. interim administrator A and director of nursing B had been in formed verbally and written immediate jeopardy removal template given, and asked for an immediate jeopardy removal plan. Plan: On 5/11/22 at 10:51 a.m. the provider's removal	F 880	Identification of Others: 2. ALL residents and staff have the potential to be affected by lack of: *Appropriate resident care needs as noted above identified and precautions initiated. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by Director of Nursing. System Changes: 3. Root cause analysis conducted answered the 5 Whys: Completed 6/1/22. MOCC determined that miscommunication between hospital and facility, needing to clarify diagnosis and education on MRSA/contact precautions were the root cause of the issue. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. Administrator and DON contacted the South Dakota Quality Improvement Organization (QIN) on 6/1/2022 and discussed root cause analysis and education to prevent further incidents. Will educate all staff on MRSA at 6/7/22 staff meeting per QIN recommendation.	

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F 880	Continued From page 12 plan had been accepted. The facility provided the following acceptable removal plan: 1. Resident has been placed on contact precautions. Signs are up on the door and PPE is out as well as bins for disposal of PPE. Care plan has been updated. Nurse working tonight and all staff working tonight have been educated that patient is positive for MRSA. I updated the contact precaution policy to include putting communication on PCC, putting up the signage and getting the PPE when you note off the order of a pathogen requiring contact precautions. Staff working have reviewed the contract precautions policy and have signed that they have been educated on this. NOC shift will be educated by the NOC nurse working tonight and the day shift tomorrow will also be educated by the NOC nurse in change or report tomorrow morning. DON will be here for morning education as well. Educating all direct care staff, laundry and housekeeping on donning and doffing PPE related to contact precautions. Started this tonight with all staff available. NOC nurse will educate NOC staff and morning staff during report. DON will be here for morning education as well. Communication of any illness requiring contact precautions will be placed on PCC homepage by the nurse that notes off the order. They will also update the care plan, place signage on the door and get the appropriate PPE. On 5/11/22 at 12:45 p.m. during onsite revisit the removal plan was verified and immediate jeopardy removed, the scope and severity of this citation is level "F".	F 880	Monitoring: 4. [Do continue with plan identified for removal of immediate jeopardy, review and provide additional education for all staff]. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	6-7-22

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 _____	05/12/2022

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 13 1. Observation and interview on 5/10/22 at 9:30 a.m. with resident 18 revealed she: *Had been sitting with the head of bed elevated. *Had lived in the facility since 6/20/10. *Had worn oxygen at 2-3 liters per nasal cannula. *Would fall asleep during the interview. -Awoke with verbal stimuli. Record review of resident 18's electronic medical record revealed: *On 3/19/22 at 8:30 a.m. she had sustained injury to her right thigh. *Initial wound size had measured 12 centimeters (cm) by 29 cm. -Open areas noted to wound area. *Treatment consisted of changinf dressing daily and as needed. *On 3/25/22 resident had been transferred to hospital for an elevated white blood cell count. -She had received IV ceftriaxone and Vancomycin for a history of methacillin-resistant staph aureus (MRSA). *On 3/31/22 she returned from the hospital for treatment of aspiration pneumonia and burns. Interview on 5/10/22 at 4:30 p.m. with director of nursing B regarding resident 18 diagnosed who had been diagnoses with MRSA revealed: *She had not been aware that the resident had been diagnosed with MRSA. -MRSA had been added to resident 18's diagnosis on 3/31/22. *She had completed the infection preventionist course. *Stated the nurse that re-admitted resident 18 was the current infection preventionist. *Stated that all nurses should know when and how to place residents on precautions.	F 880		

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	435113	A. BUILDING _____ B. WING _____	05/12/2022

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 14 *Agreed that resident 18 should have been placed on contact precaution upon return to the facility. B. Based on observation, interview, and manufacturer's instructions review, the provider failed to follow instructions for disinfecting one of one observed whirlpool tub cleaning. Findings include: Observation and interview on 5/12/22 at 8:25 a.m. during a whirlpool tub disinfection by certified nursing assistant (CNA) H revealed after each bath she: *Closed the drain. *Filled the tub with water up to just below the overflow drain. *Pushed the disinfection button for five seconds to put the Cascade disinfectant in the tub. *Started the air jets. *Used a long-handled brush to clean every surface of the tub. *Allowed the jets to continue while she waited for the disinfectant's ten-minute wet time. *Sprayed the tub chair that had remained outside the tub with Vindicator (disinfectant) and scrubbed the chair, then waited the disinfectant's ten-minute wet time. *After the ten-minute disinfection she drained the disinfectant and sprayed the tub and chair with clean water. Interview with the CNA H during the above process revealed: *She had worked as the bath aide for approximately eighteen months. *She had been trained to disinfect the tub and chair in the above manner. *There was not a tub cleaning guide posted in the	F 880		

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	435113	A. BUILDING _____ B. WING _____	05/12/2022

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

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F 880	Continued From page 15	F 880		

tub room.
*She removed a black binder from the cupboard beside the tub. The binder contained the tub disinfection guide.
*She was not aware the tub was not to be filled with water during the disinfection.

Interview on 5/12/22 at 10:35 a.m. with the director on nursing (DON) B regarding the disinfection of the whirlpool tub confirmed:
* CNA H had:
-Not disinfected the whirlpool tub according to the whirlpool manufacturer's instructions.
-Not used enough disinfectant to adequately disinfect the tub.
*The provider used the manufacturer's instructions as a policy for the tub disinfection.
*The tub was not to be filled with water during the disinfection process.
*The whirlpool tub had been used by the nursing home and assisted living residents.

Review of the manufacturer's disinfection instructions revealed:
*The "Tub Fill Button" should have been pressed and the "Temperature Control Knob" should have been turned all the way to the left to heat the disinfectant.
*Residue should have been removed from the tub using the shower sprayer.
*The "Tub Fill Button" should have been pressed again to turn the water off.
*The tub should have been allowed to drain completely and the drain plug placed over the drain.

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	435113	A. BUILDING _____ B. WING _____	05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 16 *The "Disinfectant Button" should have been continuously pressed until 1 to 1.5 gallons of disinfectant solution was in the footwell of the tub. *The disinfectant solution should have been: -Scrubbed on all surfaces of the tub. -Left on the tub surfaces for ten minutes. *After the ten minutes, the tub should have been drained and rinsed using the shower sprayer and the "Rinse" button until clear water ran through the air-jets. *Then, the "Aqua-Aire Button" should have been pressed and allowed to run for 30 seconds to push the rinse water out of the air injection system.	F 880	Manufacturers directions for cleaning whirlpool have been posted in the cabinet next to the whirlpool. Policy has been updated to include the manufacturers directions on cleaning. CNA and nursing staff educated on whirlpool cleaning during all staff meeting on 5/25/22. Also provided education during staff meeting 6/7/22. Director of nursing or designee will begin auditing whirlpool cleaning on 5/31/222 and will audit at least five whirlpool cleanings a week for three months then three whirlpool cleanings for three months then one whirlpool cleaning a week for six months. DON or designee will bring results of audits to QAPI monthly for review and recommendation.	6-7-22
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review the provider failed to ensure in a census of twenty-seven, seven of seven residents (7, 8, 12, 13, 18, 22, 25) with side rails had a preventive maintenance assessment completed ensuring the rails were compatible with the bed frame and the residents were safe from possible entrapment. Findings include: 1. Random observations 5/10/22 from 1:30 PM through 4:00 PM of all resident rooms revealed	F 909		

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	435113	A. BUILDING _____ B. WING _____	05/12/2022

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

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F 909	Continued From page 17 positioning rails were present for seven of the twenty-seven residents. 2. Interview on 5/12/22 at 8:08 AM with interim administrator A revealed: *The maintenance person was responsible for the preventive maintenace assessment. -The facility had not had a maintenance person since August 2021. *At one time they had a form to assess for bed safety. *It had not been done for some time. 3. Review of provider's June 2019 revised Proper Use of Side Rails policy revealed: *"When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used)."	F 909	7/7 residents that use side rails have had the bed/side rails assessed for safety on 5/25/22 by the administrator and will be assessed on a semi-annual basis by maintenance or designee. Bed/side rail inspection policy updated. Bed/side rail inspection added to preventative maintenance checklist on a 6-month rotation. Care team will notify maintenance if a side rail is added to a care plan to ensure safety assessment is completed on bed/side rail upon installation. Administrator or designee will audit the preventative maintenance checklist monthly to ensure assessment is completed timely and bring results of audit to QAPI for review and recommendations.	6-1-2022

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

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	435113	A. BUILDING _____ B. WING _____	05/12/2022

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

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E 000	Initial Comments A recertification survey for compliance with all applicable Federal, State, and local Emergency Preparedness requirements was conducted from 5/10/22 through 5/12/22. Menno-Olivet Care Center was found in compliance with 42 CFR Part 483.73 requirements for emergency preparedness.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lacee Feltman, MSN, LNHA

TITLE: Interim Administrator

(X6) DATE

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

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	435113	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2022**

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

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/10/22. Menno-Olivet Care Center (Bldg 01) 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 deficiency identified at K293 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain continuous illumination for 2 randomly observed exit signs (sunroom exit and main entrance). Findings include: 1. Observation beginning on 5/10/22 at 1:37 p.m. revealed the exit sign for the sunroom was not lit, it had two incandescent lamps not functioning in the fixture. Further observation of the lighted exit sign at the main entrance revealed those same	K 293	Exit lights at main entrance and sunroom had bulbs replaced on 5/12/22 and now illuminate appropriately. All other exit signs were checked to ensure appropriate functionality as well. Administrator or designee will audit all exit signs monthly to ensure they are illuminated appropriately. Any issues will be immediately corrected and results of audit will be brought to QAPI monthly by administrator for review and recommendation.	5/12/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lacee Feltman, MSN, LNHA
TITLE: Interim Administrator
(X6) DATE: 6-1-22

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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 _____	**05/10/2022**

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

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K 293	Continued From page 1 conditions existed. Interview with the administrator at the time of the observations confirmed those conditions. The deficiency affected two locations required to be provided with a marked and identifiable path of egress.	K 293		

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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 _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/10/22. Menno-Olivet Care Center (Bldg 02) was found in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Lacee Feltman, MSN, LNHA

TITLE
Interim Administrator

(X6) DATE

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JUN 01 2022

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

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	435113	A. BUILDING **03 - BUILDING 03** B. WING _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/10/22. Menno-Olivet Care Center (Bldg 03) was found in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lacee Feltman, MSN, LNHA

TITLE: Interim Administrator

(X6) DATE: 6-1-22

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10648	A. BUILDING: _____ B. WING _____	05/12/2022

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

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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 5/10/22 through 5/12/22. Menno-Olivet Care Center was found not in compliance with the following requirement(s): S157.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in three randomly observed resident room toilet rooms (101, 208, and 301). Findings include: 1. Observation on 5/10/22 at 11:20 a.m. revealed the exhaust ventilation for the toilet room in resident room 301 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the administrator at that same time confirmed that finding. She revealed she was unaware as to why the exhaust ventilation was not working at that location. She further added they had HVAC technicians in the building the day prior and believed they might have caused this issue. She also stated the rooftop exhaust fan that served that room also served all other rooms in the 300 wing. 2. Observation on 5/10/22 at 11:38 a.m. revealed	S 157	Electrician has been contacted about ventilation system 5/10/22. Will need to replace several items on the rooftop system. Parts have been ordered to repair/replace the nonfunctioning components. When units are functioning again administrator or designee will audit two exhaust vents in each wing (100, 200 and 300) wing weekly for four weeks then will remain on monthly inspections. Results of audits will be brought to QAPI for review and recommendation.	6/7/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lacee Feltman, MSN, LNHA

TITLE: Interim Administrator

(X6) DATE: 6-2-22

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 _____	05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 157	Continued From page 1 the exhaust ventilation for the toilet room in resident room 208 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the administrator at that same time confirmed that finding. She stated she would have the HVAC technicians come to fix this issue immediately. She further stated the rooftop exhaust fan that served that room also served all other rooms in the 200 wing. 3. Observation 5/10/22 at 1:59 p.m. on revealed the exhaust ventilation for the toilet room in resident room 101 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the administrator at that same time confirmed that finding. She stated she had just been informed that the buildings exhaust system was not able to be fixed and needed to be replaced. She further stated the rooftop exhaust fan that served that room also served all other rooms in the 100 wing. Those rooms were required to have exhaust ventilation directed to the exterior of the building.	S 157		