STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435113	A. BUILDING _____ B. WING _____	C 11/30/2023

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

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/29/23 through 11/30/23. The area surveyed was accidents. Menno-Olivet Care Center was found not in compliance with the following requirement: F684.	F 000	F 684 Action Items 1. The Administrator and DON, along with consultation of the Medical Director will review and revise the policies as necessary for Acute Condition Changes - Clinical Protocol,Change in a Resident's Condition or Status, Emergency Procedures - Choking, and Emergency Procedures - CPR. The Administrator and/or DON will educate staff on these updated policies and review where to locate these policies. 2. A mandatory in-service for all staff will be held in-person on three different occasions. This in-service will be led by the Administrator and/or DON. One-on-one in-service education will also be provided to ensure staff receives this training. In-service agenda items will include but are not limited to: policy and procedure updates, Stop and Watch tracking form. The Administrator and/or DON will review with staff their roles for using this form and how the charge nurse and DON will follow up on any resident concerns. Other agenda topics will include naming Risk Team members and the purpose of these meetings to ensure each resident is reviewed at regular intervals which is evident by ensuring documentation supports assessments and interventions, care plans are	12/26/23
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility report, record review, observation, interview, and policy review, the provider failed to ensure one of one sampled discharged resident (1) had been thoroughly assessed by nursing for change in condition and appropriately care planned for increased need for supervision and assistance with eating prior to a final choking event. Findings include: 1. Review of the 11/26/23 SD DOH facility report revealed: *On 11/25/23 at 5:40 p.m. resident 1 had been seated in the dining room for supper and had been served a ham sandwich that was his normal diet order.	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Kettwig
TITLE: Administrator
(X6) DATE: 12/21/2023

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.

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F 684	Continued From page 1 -Registered nurse (RN) C entered the dining room and noticed his color was grayish-blue and lips were purple. -Certified nurse assistant (CNA) A was attempting to get his arms up and get him to cough as she had noted his color had changed and he was trying to cough. *Resident 1 had lost consciousness, the nursing staff and dietary staff present removed him from his wheelchair, laid him on the floor, performed the Heimlich maneuver, and were able to remove a large amount of lunch meat from his throat. -While that care was provided, other staff summoned emergency medical services (EMS) and the EMS transported him to the hospital. Review of resident 1's electronic medical record (EMR) between 9/5/23 and 11/25/23 revealed: *On 9/5/23, a quarterly Minimum Data Set (MDS) social services note indicated he had a brief interview for mental status score of 15. He had no problems with cognition and was able to communicate his needs and understood what was being said to him. *On 9/14/23 a nursing services MDS Note: He required extensive assistance of 2 staff with bed mobility, transfers, dressing, toilet use, and bathing. He was independent with eating. He continued to have a supra-pubic urinary catheter. He was continent of bowel. *On 9/14/23 a dietary services MDS: He was on a regular texture diet. He went to the dining room for all his meals and ate independently. He did need to avoid raw vegetables and nuts due to not having any teeth. *On 9/22/23 at 10:32 a.m. a communication with physician: He ordered Cipro 500 milligram (mg) twice a day (BID) for 10 days and then recheck urinalysis (UA).	F 684	reviewed, and ensuring concerns are addressed in a timely manner. The heimlich maneuer and CPR requirements will be discussed. Education will be provided to staff regaring the care plan and how staff is able to find information regarding each resident. It will be communicated to all staff that the dietary manager needs to be notified of resident seating arrangements and the need for a resident to be at a supervised dining table. Dietary manager will be responsible for following up and care planning any such change as indicated. 3. System change is needed in our facility to improve upon identifying significant and/or acute changes in residents and ensuring documentation supports assessments and interventions in a timely manner. 4. The Administrator and DON, or designee, will audit the new processes put into place. The Risk Team will meet at least weekly for two months, twice a month for two months, and then monthly for one month. Audits will be performed by the Administrator, or designee, while reviewing the previous notes to see if concerns have been addressed. The DON will audit the Stop and Watch forms to make sure both copies are received. Verification will also be done by DON to make sure proper	

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F 684	Continued From page 2 *On 9/22/23 1:30 p.m. a health status note (late entry): Staff reported residents Depends incontinent brief was soaked with urine. The catheter tubing had a thick settling of urine with sediment. His catheter was changed using sterile technique and a return of slightly pink, cloudy, thick urine. Physician notified and a UA was ordered. *On 11/6/23 1:26 p.m. a health status note: Reported that resident had disconnected part of his catheter tubing during the night. He was also confused. Resident has been lethargic, sleeping in his wheelchair after being assisted up by the nurse's station before his noon meal. Informed the physician assistant (PA-C) when resident had changes in his mentation and has lethargy he had a urinary tract infection (UTI). This was sent to the PA-C by facsimile. *On 11/6/23 at 1:28 p.m. a order note: Order received for UA and to culture if UA indicated an infection. *On 11/7/23 at 12:18 a.m. a laboratory result note: UA results had not shown an infection so a culture was not completed. Results sent to PA-C by facsimile. *On 11/8/23 a health status notes from 1:39 a.m. through 3:28 a.m. resident vomited twice. His skin color was pale. He had received a COVID-19 booster on 11/7/23. *Health status notes from 11/8/23 at 5:31 a.m. through 11/11/23 at 9:50 a.m. revealed: -He stated he had not felt good. -He appeared tired. -Attempted to leave the facility. -Had a Wanderguard device put on his wheelchair. -Tried to get his legs out of bed by putting his legs over the side of the bed. *On 11/11/23 at 12:53 a.m. a health status note:	F 684	assessments and documentation have been completed with communication initiated to the appropriate constitutents. The DON or designee will review all skilled and assisted living residents to determine if there will be a need for additional monitoring, further assessments and/or if any documentation or interventions need to be addressed. This review will be done by the DON or designee once weekly for sixteen weeks and then every other week for sixteen weeks. The Dietary Manager will be auditing seating arrangements to ensure residents are at the appropriate spot at the dining table. Audits will be done once a week for eight weeks and then twice a month for eight weeks. All audit reports will be taken to the facility's QAPI meeting to determine if further monitoring is needed for these interventions or if substantial compliance has been met.	

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F 684	Continued From page 3 "CNAs [certified nursing assistants] alerted by other resident that [resident 1] was choking on his dinner. CNA calls RN [registered nurse] over radio to come to the dining room. [resident 1] was coughing up food when the RN entered dining room. He did have a large amount of undigested food on his shirt and pants. This RN stayed with the resident for 45 minutes encouraging him to keep coughing and spitting out the secretions that were coming out. He continued to have thick white secretions for about an hour. His vital signs are stable at this time - see vital signs. Lung sounds are slightly wheezy. Non-labored breathing at this time. He was assisted to the bathroom where his clothes were changes and he was brought back to sit outside of the nurse's station for observation. He is resting comfortably and states that he is feeling better. He still has the occasional cough. His voice is clear when he speaks." *On 11/11/23 at 7:38 p.m. a health status note: resident with possible aspiration of his noon meal. Lung sounds with audible wheezes. *On 11/14/23 at 2:11 a.m. a incident note: Resident was found on his knees in the bathroom holding onto the grab bar. Was incontinent of a bowel movement. *Behavior, incident, and infection progress notes from 11/14/23 at 12:23 p.m. through 11/17/23 at 10:15 a.m. revealed: -Monitoring of his UTI and antibiotic. -Behaviors of attempting to elope and sexually inappropriateness to the CNAs. -Attempting to get out of bed. *On 11/17/23 at 4:51 p.m. a physicians order from the on-call physician revealed: "He stated [resident 1] urine had some bacteria but they thought it might have been contaminated. New orders to STOP Cipro. Start Keflex 500 mg po [by	F 684		

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F 684	Continued From page 4 mouth] QID [four times a day] for 7 days. Follow up in ER [emergency room] if worse over the weekend. Follow up in clinic or repeat NH [nursing home] evaluation if no better 5-7 days." -He had not been seen in the ER, nor had the provider been contacted after the above order had been received. *On 11/25/23 at 6:44 p.m. a health status note revealed: -"[Resident 1) did lose consciousness et [and] was laid on floor. Staff continued the Himelick [Heimlich] maneuver until lunch meat was removed." "His POA [power of attorney] was notified that he was transferred [name of hospital]." -"1740 [5:40 p.m.} Recorder went to Dining Room et [and] noticed that [resident 1] color was greyish blue et lips were purple. CNA was trying to get his arms up et get him to cough. We laid him on the floor et did the Himelich Maneuver. Several staff members tried to clear throat. CNA did mouth swipe et pulled large amt [amount] of lunch meat out of his throat. He did take a deep breath but color was still blue. Call placed at 1745 [5:45 p.m.] to [director of nursing] et EMT [emergency medical technician]. 1743 [5:43 p.m.] EMTs arrived and DON arrived. Agonal breathing [abnormal pattern of breathing characterized by labored, gasping breaths that occur because of insufficient oxygen] et light pulse. [resident 1] was bagged [artificial respirations] until EMTs arrived. Ambulance left with resident to [hospital]." Review of an 11/6/23 nurses request to the PA-C and subsequent order for resident 1 revealed: *"[Resident 1] having increased confusion, very lethargic today. He does get changes in mentation/behavior with UTI's. He has Supra Pubic cath [catheter] and was changed last week	F 684		

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F 684	Continued From page 5 on 10/31/23. May we check UA please?" *The PA-C gave the order UA with reflex [culture if positive for infection]. Review of an 11/8/23 nurses request to the physician and subsequent order for resident 1 included: *Had vomiting during the night, skin color is pale, respirations labored, oxygen started at 3 liters per nasal canula. *Had audible wheezing noted. Resident had COVID-19 booster on 11/7/23. *Was started on Cipro 500 mg BID on 11/7/23 for a questionable UTI even though the UA was not positive. *As for an order for as need Zofran. *Order received for Zofran 4 mg every 8 hours as need for nausea and vomiting. Review of a 11/11/23 nurses request to the physician and subsequent order for resident 1 included: *A request for laboratory tests complete blood count (CBC) and comprehensive metabolic panel (CMP). *He had increased confusion since he had received his COVID-19 and respiratory syncytial virus (RSV) vaccines on 11/7/23. *The physician replied with a "yes." Review of a 11/13/23 nurses request to the physician and subsequent order for resident 1 included: *Resident continued to have changes in his mental status and now having inappropriate sexual behaviors. *UA was completed but not cultured. Started on Cipro 500 mg BID for 10 days on 11/7/23. Still dealing with issues.	F 684		

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F 684	Continued From page 6 *Asked if should try a different medication. *The physician increased resident 1's fluoxetine to 30 mg daily for sexually inappropriate behaviors. Review of a 11/17/23 nursing home order sheet from the on-call physician for resident 1. There are no notes only the orders which included: *Stop Cipro. *Start Keflex 500 mgt QID for 7 days. *Follow-up in ER if worse over the weekend. *Follow-up in clinic with repeat nursing home evaluation if no better in 5 to 7 days. Observation and interview on 11/29/23 at 11:30 a.m. with CNA A revealed she: *Was in the dining room and was assigned to assist residents to eat their noon meal. *Showed the surveyor where resident 1 had sat. *The area where he had been seated was a table that two residents would have used to dine, It was within five feet to the right of a large round table where all of the residents who required total assistance with eating sat. *Was not sure when he had been moved to the assisted area. *Had thought it was when he had his first choking episode. Interview on 11/29/23 at 11:45 a.m. with dietary manager B revealed: *Resident 1 had been sleepier in the last couple of weeks. *He had the COVID-19 booster and it had really made him sick. *She was not sure when he had been moved to the assisted dining area. *She was aware he had a previous choking episode so she thought it was after that.	F 684		

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F 684	Continued From page 7 *His diet texture had not been changed. *She had not consulted the registered dietitian. Interview on 11/29/23 at 12:10 p.m. with RN C revealed: *Resident 1 had a significant decline in the last 2-3 weeks. *It had started with a UTI but even with antibiotics he had not seemed to get better. *He would attempt to leave the facility. *He had received both his COVID-19 booster and RSV vaccination on the same day. *She was not sure of the exact date he had those immunizations. *She did not know when he had been moved to the assisted area in the dining room. *He did need assistance with eating at times since he had been moved to the assisted area. *He would also fall asleep at times during his meals. Interview on 11/29/23 at 2:20 p.m. with CNA D revealed: *Resident 1 had declined in the last few weeks. *He used to be able tell me what he wanted, he was not able to do that anymore. *He did not use his call light anymore. *He tried to crawl out of bed. *He was incontinent of bowel. *Normally he was independent with eating but then he had problems with eating. She thought he had been moved to the assisted dining area due to him being a choking risk. *He had been found on the floor twice. He had not fallen since she has been here. *He was transferred with the sit-to-stand lift. Continued interview on 11/29/23 at 3:00 p.m. with CNA A revealed:	F 684		

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F 684	Continued From page 8 *She had worked with resident 1 for approximately 2 years. *He would have a slight decline when he had a UTI, but not like this or for this long. *His decline was significant to her. *He did have to been assisted to eat at times. He would fall asleep at times. Interview on 11/30/23 at 10:15 a.m. with administrator E and DON F revealed: *They had been aware of resident 1's significant change of condition. *They were not sure when he had been moved to the assisted dining area. *There were residents who had been eating in their rooms due to COVID-19 and as he had been wandering, he had just been placed there to eat one day. *They confirmed he had not been moved to the assisted dining area due to his decline and choking episode on 11/11/23. *Agreed the physician had not been notified of his choking incident from 11/11/23. *His primary care provider (PCP) had been changed per his POAs request. Due to his new PCP being very ill, the PA-C had initially established care on 10/17/23. *The interdisciplinary team had a weekly risk management meeting to discuss all the residents. They had identified his change of condition and had scheduled a significant change of condition MDS assessment. *No one had thought about changing his diet texture to decrease his risk of choking. *They agreed they should have had a physician examine him or send him to the ER. Review of resident 1's 6/17/20 care plan revealed:	F 684		

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F 684	Continued From page 9 *He was independent in eating. *Diet as ordered. Consult with dietitian and change if chewing or swallowing problems were noted. Review of the provider's undated Texture and Consistency-Modified Diets policy revealed: *Individuals with observed indicators of dysphagia (coughing, choking, delayed swallow, pocketing of food, etc,) would be referred to the speech language pathologist (SLP) for the evaluation of dysphagia. *Individuals who needed a change in diet consistency could be placed on a mechanical soft diet, chopped, ground, or pureed foods. Diets would be adjusted to meet individual needs. Review of the provider's revised March 2018 Acute Condition Changes - Clinical Protocol/Guidelines policy: *The physician would help identify individuals with a significant risk for having acute changes of condition during their stay; for example, a resident with an indwelling urinary catheter who has had recurrent symptomatic urinary tract infections. *The nurse shall assess and document and report baseline information including: -Vital signs. -Neurological status. -Level of consciousness. -Onset, duration, and severity. -All active diagnoses. -All current medications. *Direct care staff, including, nursing assistants would be trained in recognizing subtle significant changes in the resident (for example, decrease in food intake, increased agitation, changes in skin color, or condition) and how to communicate	F 684		

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F 684	Continued From page 10 those changes to the nurse. Review of the provider's revised May 2017 Change in a Resident's Condition or Status policy revealed: *The nurse would notify the resident's attending physician or physician on call when there has been an: -Need to alter the resident's medical treatment significantly. -Specific instruction to notify the physician of changes in the resident's condition. -Significant change in the resident's physical condition. *A significant change of condition is a major decline in the resident's status that: -Would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. -Impacts more than one area of the resident's health status. -Requires interdisciplinary review and/or revision to the care plan. -Ultimately is based on the judgement of the clinical staff and clinical guidelines for standards of care.	F 684		