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

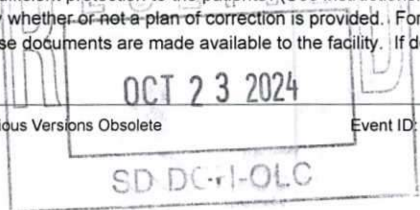
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435102	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONUMENT HEALTH STURGIS CARE CENTER	2140 JUNCTION AVENUE STURGIS, SD 57785

(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 10/1/24 through 10/3/24. Monument Health Sturgis Care Center was found not in compliance with the following requirements: F658, F677, F690, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/1/24 through 10/3/24. The area surveyed was resident elopement. Monument Health Sturgis Care Center was found in compliance.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one registered nurse (RN)(J) had prepared and administered insulin according to the physician order and provider policy for one of one sampled resident (25). Findings include: 1. Observation and treatment administration record (TAR) review on 10/3/24 at 9:27 a.m. of RN J, while he prepared insulin for resident 25, revealed: *Resident 25's TAR indicated she was to be given 10 units of Novolog insulin every morning after	F 658	F 658 Corrective Action: 1. For the identification of and lack of provider failing to ensure there was licensed nursing oversight and supervisor to ensure that Nurses in the facility had received initial and annual education for preparing and administering insulin according to the physician order and provider policy was corrected by nurse J reviewing the injection policy section titled insulin injection on 10/3/24 DON followed up nurse J on 10/3/24 and he denied any questions related to injecting insulin. 2. Identification of Others All current and future nurses are potentially affected by the deficiency of the provider failing to ensure there was licensed nurse oversite and supervision to ensure that all nurses in the facility are competent with administering insulin.	11/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark C Schmidt	President	10/23/2024

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 658	Continued From page 1 breakfast along with sliding scale (additional dose based on blood sugar level) Novolog if her blood glucose was greater than 150. -There was an order to "Hold Novolog at breakfast if resident does not eat. If her glucose level is elevated, use sliding scale but do not give scheduled." -She had a continuous glucose monitor that was placed in her upper left arm and an order for self-administration of insulin. *RN J verified the resident had eaten her breakfast. *RN J cleansed the resident's insulin auto-injector port with an alcohol pad, applied the needle to the auto-injector, and dialed up 8 units of insulin for administration, not the ordered 10 units of insulin. -He had not primed the insulin needle with insulin before dialing up the incorrect dosage of 8 units of insulin. *This surveyor stopped RN J at the door of the resident's room and asked that he double-check the TAR for the correct dosage. -RN J checked the order, verified the correct dosage was 10 units and dialed up an additional 2 units of insulin into the pen and then returned to the resident's room. *He verified resident 25's blood glucose level to be 108 and informed the resident she would not receive any sliding scale insulin that morning. -He handed the insulin auto-injector to the resident and she self-injected the insulin correctly into her abdomen. *Following the administration of the insulin, RN J returned to the cart and documented the 10 units of insulin were administered. 2. Interview on 10/3/24 at 9:30 a.m. with RN J regarding the above insulin preparation and administration revealed:	F 658	The facility will ensure future and current nurses will complete initial and annual nurse competencies to ensure they are competent in insulin administration. Insulin administration competencies will be tracked by the DON or designee to ensure completion. All identified education was provided to all specified staff, no later than 11/15/24, or before their next scheduled shift if unable to receive education prior to 11/15/24. The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies and procedures for the above identified areas. Monitoring: Audit tool has been created to focus on ensuring nurses within the facility are competent with insulin administration. The nurse insulin administration audit tool will continue for a minimum of 6 months. (i.e. two quarterly QAPI meeting cycles) at which point the decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee.	

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F 658	Continued From page 2 *He had been a licensed nurse for over 15 years, and this was his first assignment working for a temporary agency. He had been assigned to this provider for nearly three months. -He stated he had not been asked to perform an insulin administration skills audit for this provider. *He stated he was not aware auto-injector insulin pens needed to have their needles primed with insulin before dialing up the insulin dosage. -He stated, "Probably a good thing to know. Didn't know that." *He verified it was not his usual practice to prime the insulin needle on auto-injector insulin pens. 3. Interview on 10/3/24 at 9:45 a.m. with director of nursing/infection preventionist (DON/IP) B regarding the above observation of RN J revealed: *RN J had been working for them as a temporary nurse since 7/8/24. *She stated she assumed travel nurses did insulin skills education with their travel agency of employment. *She had not audited her nursing staff for insulin injection skills, stating since they were licensed nurses, she would have expected them to know how to administer insulin correctly. *She had to refer to their policy to verify the correct dose of insulin that was needed to prime the auto-injector needle. -After a review of the policy, she verified the needle should have been primed with 2 units of insulin. *It was her expectation that the nursing staff would know how to prime the auto-injector needle before dialing up the insulin dose. She agreed that had not occurred. 4. Review of the temporary agency's 5/23/24	F 658	For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional education opportunities will be directed by QAPI committee in response to audit reports. Audit tool has been created to audit that nurses are competent with insulin administration. Audits will be performed by DON or designee. 3 to 5 audits will be performed weekly. After 4 weeks of monitoring, demonstrating expectations are being met, monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months.	

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F 658	Continued From page 3 Skills Checklist on RN J revealed he had shown proficiency on a "level 4" on a scale of 1-4 under the skill of "insulin administration", meaning he could "serve as a resource" for insulin administration. The skills review had not included what items were audited under each topic of review. 5. Review of the provider's 3/2023 Injections policy revealed: *"Insulin Injection" -"5. Prime the needle." -"5. a. Turn the dose selector to select 2 units of insulin." -"5. b. Hold the pen with the needle pointing up. Press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. " -"5. c. ...If no insulin drop is seen at the tip of the needle, change the needle and repeat steps 5a and 5b." -"5. d. Do not administer insulin unless priming drop is visualized."	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure oral hygiene was provided for three sampled residents (3, 45, and 148) who were dependent on staff for their care needs according to their personalized care plan and facility policy.	F 677	F 677 Corrective Action: 1. For the identification of and lack of provider failing to ensure there was oral hygiene was provided for residents who are dependent on staff for their care needs according to their care plan and provider policy. . All nursing caregivers were educated on 10/22/24 that all residents that are dependent on staff for their care needs according to their care plan need will need oral care completed both morning and bedtime unless a resident refuses or their care plan says otherwise.	11/15/24

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F 677	Continued From page 4 Findings include: 1. Observation on 10/1/24 at 8:40 a.m. of resident 3 while sitting in a wheelchair in her room and interview with her visiting daughter revealed: *The resident was able to answer simple questions but was very hard of hearing and had poor vision. -Her daughter stated the resident had returned from the hospital yesterday (9/30/24) following a suspected heart attack last Thursday (9/26/24). -When asked if she had any concerns regarding her mother's care, the daughter stated, "Her oral care could be better." Review of resident 3's electronic medical record (EMR) revealed: *She had a Brief Interview of Mental Status (BIMS) assessment score of 12, which indicated she was moderately cognitively impaired. *Her 7/4/24 care plan revealed she had her own teeth and required partial to moderate assistance from one staff member to provide her oral care upon rising and at HS (hour of sleep) or twice a day. *Review of the certified nurse aide (CNA) task documentation of her oral care provided in the last 30 days, from 9/2/24 through 10/2/24, revealed she had received oral care for 10 out of 52 opportunities (subtracting the four days she had been hospitalized). -During that period, staff did not provide her oral care 42 times. 2. Observation and interview on 10/1/24 at 4:42 p.m. with resident 45 and his wife, who was his power of attorney (POA), revealed: *His wife was in his room while he rested in bed and agreed to be interviewed.	F 677	2. Identification of Others All current and future residents are potentially affected by the deficiency of not ensuring there is oral hygiene provided for residents who are dependent on staff for their care needs according to their care plan and provider policy. The facility will ensure future and current nursing staff will complete initial and annual education to ensure they are competent on providers' oral hygiene: conscious resident procedure. Oral hygiene: Conscious resident procedure education will be tracked by the DON or designee to ensure completion. All identified education was provided to all specified staff, no later than 11/15/24, or before their next scheduled shift if unable to receive education prior to 11/15/24. The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies and procedures for the above identified areas.	

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F 677	Continued From page 5 *Her only concern regarding his care was the staff not providing oral care. -She stated, "I always give him oral care when I come to visit, not sure the aides would do it." -Recently she had to clean dried food off his mustache that had been "caked on." Review of resident 45's EMR revealed: *He was receiving hospice care and had a BIMS score of two, which indicated he had severe cognitive impairment. *His 7/8/24 care plan revealed he had his own teeth and required partial to moderate assistance from one staff member to provide his oral care upon rising and at HS. *Review of the CNA task documentation of his oral care provided in the last 30 days, from 9/2/24 through 10/2/24, revealed he had received oral care for 10 out of 60 opportunities with one refusal documented. -During that period, staff did not provide him oral care 49 times. 3. Observation on 10/1/24 at 4:08 p.m. of resident 148 while he slept in his bed revealed: *He was breathing with his mouth open, and he had a slimy phlegm build-up in the corners of his mouth, a white pasty build-up on his teeth along his red-rimmed gums, and his tongue had a yellowish-white fuzzy coating. -His right lower lip had several dark pink areas. *Resident 148 awoke during the surveyor's presence and nodded his head yes when asked if he was agreeable to the interview. -He was unable to speak and was given his word communication sheet that was sitting on his dresser. -He was unable to confirm if the CNAs provided him with oral care.	F 677	Monitoring: Audit tool has been created to focus on ensuring nursing staff within the facility are competent with oral hygiene: Conscious Resident The nursing staff oral hygiene: Conscious Resident audit tool will continue for a minimum of 6 months. (i.e. two quarterly QAPI meeting cycles) at which point the decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional education opportunities will be directed by QAPI committee in response to audit reports. Audit tool has been created to audit that nurses are competent with oral hygiene: Conscious Resident. Audits will be performed by DON or designee. 3 to 5 audits will be performed weekly. After 4 weeks of monitoring, demonstrating expectations are being met, monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months.	

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F 677	Continued From page 6 Review of resident 148's EMR revealed: *He had a BIMS score of five, which indicated he had severe cognitive impairment. *His 7/16/24 care plan revealed he had his own teeth and required substantial to maximal assistance from one staff member to provide his oral care upon rising and at HS. He also had a chipped tooth on his right upper side. *Review of the CNA task documentation of his oral care provided in the last 30 days, from 9/2/24 through 10/2/24, revealed he had received oral care for 13 out of 60 opportunities. -During that period, staff did not provide him oral care 47 times. Interview on 10/3/24 with director of nursing/ infection preventionist (DON/IP) B regarding CNAs provision of oral care to dependent residents revealed: *Her expectation was for oral care to be offered or provided to all residents twice a day and documented. -She was not aware those cares were not being provided according to their care plans or policy. Review of the provider's 1/1/24 Oral Hygiene: Conscious Resident policy revealed: *"Key procedural Points:" -"1. Provide dental care in the morning and at bedtime. Or as indicated by provider." -"7. Examine the resident's mouth and gums at for any paleness of gums, broken or loose teeth, decaying teeth, mouth sores, and areas of discoloration." *"Post-Procedure: Demonstrates proper technique for providing oral care." -"3. Report any changes in patient condition to nurse."	F 677		

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F 677	Continued From page 7 -"4. Documents procedure in HER [electronic health record/EHR]."	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690	F 690 Corrective Action: 1. For the identification of and lack of provider failing to ensure there were interventions to lessen the occurrence of urinary tract infections for one resident, a urinalysis was completed on 10/2/24 for resident 14. Urinalysis determined to be negative on 10/2/24. Estimated daily fluid intake goals were reviewed for resident 14 and determined to be within limits for her estimated fluid intake goals. Education provided to CNAs O, L and UMA P on 10/22/24, resident 14's estimated daily fluid intake goals are located on her care plan (Kardex) in providers EMR. Resident 14 care plan reviewed. Residents 14 care plan says that this resident will refuse to eat or drink due to the diagnosis of depression r/t Dementia. Care plan also says this resident is able to eat/drink independently. Resident 14's care plan edited to include, I will refuse food and fluids at times due to my diagnosis of psychotic disorder with hallucinations. Peri care and handwashing/glove use education provided to CNAs L and K on 10/22/24.	11/15/24

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F 690	Continued From page 8 possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure interventions to lessen the occurrence of urinary tract infections (UTI) were implemented for one of one resident (14) who had a UTI. Findings include: 1. Observation on 10/2/24 between 11:30 a.m. and 12:15 p.m. of resident 14 in the dining room revealed: *A plastic cup of ice water and another cup of juice were served to the resident with her meal. -She ate and drank independently. *Both cups remained mostly full at the end of the meal. -Staff provided no verbal cueing or encouragement to the resident to drink those fluids during the meal service. Review of resident 14's electronic medical record (EMR) revealed: *She was admitted to the facility on 5/9/23. *Her diagnoses included: late onset Alzheimer's disease, hypothyroidism, depression, anxiety, and gastroesophageal reflux disorder. -A UTI diagnosis was added to her profile on 9/10/24. *Her 8/15/24 Brief Interview for Mental Status (BIMS) score was 7 which indicated her cognition was severely impaired. *Her April 2024 through September 2024 interdisciplinary progress notes revealed: -Urine analyses (UA) were ordered and the resident was started on oral antibiotics for UTIs on 8/8/24, 9/12/24, and 9/26/24. -Between April 2024 and July 2024 she had no	F 690	2. Identification of Others All current and future residents are potentially affected by the deficiency of not ensuring interventions being implemented, to lessen the occurrence of urinary tract infections according to their care plan and provider policy. The facility will ensure future and current nursing staff will complete initial and annual education to ensure they are competent on providers hand hygiene (glove use) and peri care policy/procedure. The facility will ensure future and current nursing staff are educated that estimated fluid intake goals are located on each resident's care plan. Handwash hygiene (glove use) and peri care policy/procedure education will be tracked by the DON or designee to ensure completion. Estimated fluid intake goals located on each resident's care plan education will be tracked by the DON or designee to ensure completion. All identified education was provided to all specified staff, no later than 11/15/24, or before their next scheduled shift if unable to receive education prior to 11/15/24. The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies and procedures for the above identified areas.	

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F 690	Continued From page 9 documented UTIs. *Her 8/22/24 dietary assessment indicated her estimated daily fluid intake need was between 867-1214 milliliters. -Between 9/4/24 and 10/2/24 her documented daily fluids consumed was less than her estimated fluid needs on 10 of those days. -A twice-daily liquid nutritional supplement (474 milliliters) was included in that fluid intake calculation. *Between 9/4/24 and 10/2/24 her daily urinary continence documentation revealed: -She was incontinent of urine 93% of the time. *Toileting assistance was documented as occurring between one and four times each day. -83% of the time there were either two or three documented times toileting assistance occurred. Interview on 9/2/24 at 4:00 p.m. with registered nurse J regarding UTI prevention interventions for resident 14 revealed certified nurse aides were expected to provide the resident with appropriate peri-care to lessen her risk for UTIs. Interview on 9/2/24 at 4:10 p.m. with certified nurse aide (CNA) O regarding UTI prevention interventions for resident 14 revealed: *Her fluid intake was documented daily but he was not aware of what her estimated daily fluid intake needs were. *CNAs were responsible for documenting on the Urinary Continence flowsheet each time the resident was assisted to use the toilet and whether or not she continent or incontinent at those times. -The resident was incontinent of bowel and bladder, not on a scheduled toileting program, and sometimes placed her hand inside of her brief after a bowel movement (BM) then smeared	F 690	Monitoring: Audit tool has been created to focus on ensuring nursing staff within the facility are competent with hand hygiene (glove use), peri care, and individual fluid goals are located on each care plan. The nursing staff hand hygiene (glove use), peri care, and individual fluid goals are located on each care plan, audit tool will continue for a minimum of 6 months. (i.e. two quarterly QAPI meeting cycles) at which point the decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional education opportunities will be directed by QAPI committee in response to audit reports. An audit tool has been created to audit that nurses are competent hand hygiene (glove use), peri care, and individual fluid goals are located on each care plan. Audits will be performed by DON or designee. 3 to 5 audits will be performed weekly. After 4 weeks of monitoring, demonstrating expectations are being met, monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months.	

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F 690	Continued From page 10	F 690		

her BM.

Interview on 10/3/24 at 8:00 a.m. with unlicensed medication aide (UMA) P regarding resident 14's fluid intake revealed:
*The resident independently drank fluids.
*She preferred water or juice over coffee and pop.
*UMA P encouraged the resident's fluid intake by placing her nutritional supplement in a small paper cup then refilling the cup as needed.
-She thought resident 14 was able to wrap her hand around the smaller-sized paper cup better than the plastic cups that were filled with water for her.
-She had not tried using a cup with a handle to determine if resident 14 might handle that better than a plastic cup.

Interview on 10/3/24 at 8:15 a.m. with CNA/bath aide N regarding residents' bath schedules revealed:
*Resident 14 was bathed weekly on Monday.
*Some residents were bathed more than one time weekly because of their preference or a medical reason.
-She was not aware of any reason why resident 14 would have been bathed more than once weekly.

Observation and interview on 10/3/24 at 9:20 a.m. with CNAs K and L while assisting resident 14 with toileting revealed:
*The resident was transferred from her wheelchair to the sit-to-stand mechanical lift into her bathroom.
*After performing hand hygiene and placing clean gloves on her hands, CNA L removed the resident's wet incontinence brief and discarded it.

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F 690	Continued From page 11 *The resident was lowered onto the toilet but stated "I can't pee." -She was raised up from the toilet by those staff who used the lift and with those same unclean gloved hands, CNA L removed individual wipes from a container and handed them to CNA K to clean the resident's peri-area. *CNA K wiped the resident's peri-area using the wipe handed to her by CNA L. -Instead of discarding the soiled wipe after it was used, the unclean wipe was re-used to wipe the resident's peri-area again. *After a clean incontinence brief was applied and resident 14 was redressed, CNAs K and L moved her out of the bathroom with helping her perform hand hygiene. *CNA L knew she should have removed her unclean gloves, performed hand hygiene, and put on clean gloves after handling the resident's wet brief and before handing CNA L clean wipes to perform peri-care. *CNA K agreed she should have discarded each wipe after using it for peri-care rather than re-using a soiled wipe. *CNAs K and L agreed resident 14 should have been assisted with hand hygiene before she had left the bathroom. Continued observation and interview with CNA L regarding UTI prevention interventions for resident 14 revealed: *There was a lidded cup of water with a straw on the resident's nightstand. -That was placed there about 10:00 p.m. the previous night and was still full. -She had not seen the resident initiate drinking water left for her on the bedside stand. *The resident was not on a scheduled toileting program.	F 690		

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F 690	Continued From page 12 -CNA L tried to offer and assist the resident with her toilteting after each meal. *Resident 14 was not offered water from the bedside cup by CNA L before exiting the resident's room with the resident. Interview and record review on 10/3/24 at 11:45 a.m. with director of nursing (DON)/Infection Preventionist (IP) B regarding UTI prevention interventions revealed: *"Pushing fluids" [encouraging residents to drink fluids throughout the day], providing proper peri-care, and changing incontinent residents in a timely manner" were the primary interventions she expected staff to complete to prevent UTIs from occurring. *She agreed resident 14's daily fluid intake expectations were not consistently met based on her review of the fluid intake documentation referred to above. -The resident's daily fluid intakes were not monitored and there was no documentation to support what other alternatives had been attempted to increase her fluid intake. *The manner in which peri-care was provided by CNAs K and L put resident 14 at greater risk for UTI development. *Neither a scheduled toileting program nor a scheduled rounding program had been tried as an intervention to ensure the amount of time the resident was incontinent was as short as possible. *Increasing the frequency of the resident's bathing schedule had not been tried. *She tracked UTI frequency for all residents and reported that information to the Quality Assurance and Process Improvement (QAPI) team. Her focus was ensuring antibiotics prescribed for UTIs were appropriate based on urine cultures.	F 690		

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F 690	Continued From page 13 Review of the June 2024 through August 2024 UTI Data Review Reports shared with the QAPI team revealed: *The State average for UTI occurrence was 3.3% of the resident population and the national average was 2.1% *The provider's average UTI occurrences were: -In June 2024, 4.8%. -In July 2024, 8.1%. -In August 2024, 12.2%. *Their goal was to be equal to or below the national average. *Their action plan to reach that goal was "Continuance of monitoring residents and educating staff and families." A UTI Prevention policy was requested of DON/IP B on 10/3/24 at 11:10 a.m. An Infection Control Program policy revised on March 2020 was provided and revealed: *B. Responsibilities of the Director of Nursing in relationship to the infection control program included participation "in the assessment or analysis of the success/failure of key processes within the infection prevention/control program." *"D. Surveillance priorities: -1. Symptomatic Urinary Tract Infections."	F 690		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812	F 812 Corrective Action: 1. For the identification of and lack of provider failing to ensure to maintain appropriate temperatures for one of one high- temperature dishwasher utilized to clean dishes used to prepare and serve resident food items according to the manufacturer's instructions, the Dish Machine policy education was provided to dishwasher E and manager D on 10/1/24.	11/15/24

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F 812	Continued From page 14 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review the provider failed to maintain appropriate temperatures for one of one high-temperature dishwasher utilized to clean dishes used to prepare and serve resident food items according to the manufacturer's instructions. Findings included: 1. Observation and interview on 10/1/24 at 8:10 a.m. with retail manager H in the kitchen revealed: *The wash cycle temperature of the dishwasher was supposed to be between 170 and 175 degrees Fahrenheit. *The final rinse cycle temperature of the dishwasher was supposed to be between 180 and 190 degrees Fahrenheit. *The retail manager said if the temperatures of the dishwasher were below the manufacturer's recommended minimal temperature the staff were to have maintenance service the dishwasher. *The wash temperature on "The Dishmachine Temperature Record" September 2024 log was recorded as follows:	F 812	The maintenance department looked at dishwasher on 10/1/24 and determined it was working adequately per the providers policy. Identification of Others 2. All current and future residents are potentially affected by the deficiency of not ensuring to maintain appropriate temperatures for one of one, high- temperature dishwasher utilized to clean dishes used to prepare and serve resident food items according to the manufacturer's instructions per the provider policy. The facility will ensure the future and current dietary staff will complete initial and annual education to ensure they are competent on Dish machine policy. Dish Machine Policy education will be tracked by the Dietary Director or designee to ensure completion. All identified education was provided to all specified staff, no later than 11/15/24, or before their next scheduled shift if unable to receive education prior to 11/15/24. The administrator, DON, Dietary Director and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies and procedures for the above identified areas.	

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F 812	Continued From page 15 -19 out of 90 documented temperatures were below the manufacturer's recommended minimal temperature. -No corrective actions were written down as taken when the temperatures were below the manufacturer's recommended minimal temperature. *The final rinse temperature on "The Dishmachine Temperature Record" September 2024 log was recorded as follows: -36 out of 90 documented temperatures were below the manufacturer's recommended minimal temperature. - No corrective actions were written down as taken when the temperatures were below the manufacturer's recommended minimal temperature. Interview on 10/1/24 at 8:35 a.m. with kitchen director C revealed: *She had called the manufacturer's service department the past year and a half, five to six times, and had serviced the dishwasher. *The staff were to have maintenance service the dishwasher when the temperatures were below the manufacturer's recommended minimal temperature. Interview on 10/1/24 at 10:32 a.m. with kitchen manager F revealed: *She had been employed with the facility since 6/11/2019. *She usually worked in the evenings. *When the dishwasher temperature was below the manufacturer's recommended minimal temperature, she had called maintenance and they would service the dishwasher that evening and then would run the dishes back through the dishwasher at the correct temperature.	F 812	Monitoring: An audit tool has been created to focus ensure provider is maintaining appropriate temperatures for one of one high- temperature dishwasher utilized to clean dishes used to prepare and serve resident food items according to the manufacturer's instructions per the provider policy. The maintaining appropriate temperature for one of one high temperature dishwasher audit continue for a minimum of 6 months. (i.e. two quarterly QAPI meeting cycles) at which point the decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional education opportunities will be directed by QAPI committee in response to audit reports. Audit tool has been created to audit that the appropriate temperature is maintained for one of one high-temperature dishwasher. Audits will be performed by Dietary Director or designee. 3 to 5 audits will be performed weekly. After 4 weeks of monitoring, demonstrating expectations are being met, monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months.	

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F 812	Continued From page 16	F 812		

Interview on 10/1/24 at 10:43 a.m. with dishwasher E revealed:
*He had been employed with the facility since 8/10/21.
*He worked in the mornings.
*When the dishwasher temperatures were below the manufacturer's recommended minimal temperature, he had called maintenance to service the dishwasher and then would run the dishes back through the dishwasher at the correct temperature.
*He confirmed some of the morning temperatures on "The Dishmachine Temperature Record" September log were below the manufacturer's recommended minimal temperature.
-He did not call maintenance to service the dishwasher.
-He agreed he should have called maintenance to service the dishwasher.

Interview on 10/1/24 at 11:20 a.m. with cook/back of the house manager D revealed he:
*Had been employed with the facility since 1/19/2024
*Was responsible for reviewing "The Dishmachine Temperature Record" log each month for the correct temperatures.
*Would have notified the kitchen director when the temperatures were below the manufacturer's recommended minimal temperature.
*Was unaware he was supposed to write down the corrective action that was taken.

Interview on 10/2/24 at 8:59 a.m. with plant operations manager G revealed:
*Maintenance had changed a fuse in the dishwasher three times in the past year when the kitchen staff requested service due to low

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F 812	Continued From page 17 temperatures. *Maintenance had been requested once for dishwasher service during September. Interview on 10/2/24 at 11:37 a.m. with director of nursing B revealed she: *Agreed some of the temperatures on the dishwasher log were below the manufacturer's recommended minimal temperature. *Confirmed there had been no gastrointestinal illness during September. Review of the Hobart "Instructions Mode Manual" revealed: *"Minimum Temperatures Using High-Temperature" -"Wash Tank 160*F {degrees Fahrenheit}" -"Final Rinse 180*F {degrees Fahrenheit}" Review of the providers January 2024 Dishmachine Temperatures Policy revealed: *"Single-tank, conveyor, dual-temperature machine: -Wash temperate 160*F {degrees Fahrenheit} -Final rinse temperature 180-194 *F {degrees Fahrenheit}" *"Supervisor/Food and Nutrition Associate as assigned -High Temperature Dishmachine-record on Dishmachine Temperature Record form:" *"Director -Determines if reading is due to malfunctioning temperature gauge or inappropriate temperature. -Contacts sources of repairs. -Documents action taken on back of form."	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880	F 880 Corrective Action:	11/15/24

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F 880	Continued From page 18 §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 §483.71 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,	F 880	1. For the identification of and lack of provider failing to ensure infection prevention and control practices were implemented for hand hygiene/glove use, incontinence care (peri care), and resident hand hygiene assistance, Peri care (provide resident hand hygiene) and hand hygiene (glove use) education provided to CNAs I, K, and L and on 10/22/24. Peri care policy was updated to include, assist resident with hand hygiene on 10/22/24. Identification of Others 2. All current and future residents are potentially affected by the deficiency of failing to ensure infection prevention and control practices were implemented for hand hygiene (glove use), incontinence care (peri care), and resident hand hygiene assistance. The facility will ensure future and current nursing staff will complete initial and annual education to ensure they are competent on providers hand hygiene (glove use) and peri care policy/procedure (resident hand hygiene after peri care). Handwash hygiene (glove use) and peri care policy/procedure (resident hand hygiene after peri care) education will be tracked by the DON or designee to ensure completion.	

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F 880	Continued From page 19 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, record review, and policy review, the provider failed to ensure infection prevention and control practices were implemented for: *Hand hygiene and glove use by three of four certified nurse aides (CNAs) (I, K, and L) during peri-care for three of three observed residents (11, 14, and 28). *Incontinence care provided by three of three CNAs (I, K, and L) for three of three observed residents (11, 14, and 28). *Hand hygiene assistance for one of one	F 880	All identified education was provided to all specified staff, no later than 11/15/24, or before their next scheduled shift if unable to receive education prior to 11/15/24. The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies and procedures for the above identified areas. Monitoring: An audit tool has been created to audit that nursing staff are competent with hand hygiene (glove use), peri care policy/procedure (resident hand hygiene after peri care). Audits will be performed by DON or designee. 3 to 5 audits will be performed weekly. After 4 weeks of monitoring, demonstrating expectations are being met, monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months. The nursing staff hand hygiene (glove use), peri care (resident hand hygiene after peri care), audit tool will continue for a minimum of 6 months. (i.e. two quarterly QAPI meeting cycles) at which point the decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee.	

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F 880	Continued From page 20 observed resident (14) with hand hygiene following bathroom use. Findings include: 1. Observation and interview on 10/3/24 at 9:20 a.m. with CNAs K and L while assisting resident 14 with toileting revealed: *The resident was transferred from her wheelchair to the sit-to-stand mechanical lift into her bathroom. *After performing hand hygiene and placing clean gloves on her hands, CNA L removed the resident's wet incontinence brief and discarded it. *The resident was lowered onto the toilet but stated "I can't pee." -She was raised up from the toilet by those staff who used the lift and with those same unclean gloved hands, CNA L removed individual wipes from a container and handed them to CNA K to clean the resident's peri-area. *CNA K wiped the resident's peri-area using the wipe handed to her by CNA L. -Instead of discarding the soiled wipe after it was used, the unclean wipe was re-used to wipe the resident's peri-area again. *After a clean incontinence brief was applied and resident 14 was redressed, and assisted out of the bathroom without being assisted by either CNA K or L to perform hand hygiene. *CNA L knew she should have removed her unclean gloves, performed hand hygiene, and put on clean gloves after handling the resident's wet brief and before handing CNA L clean wipes to perform peri-care. *CNA K agreed she should have discarded each wipe after using it for peri-care rather than re-using a soiled wipe. *CNAs K and L agreed resident 14 should have been assisted with hand hygiene before she had	F 880	For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional education opportunities will be directed by QAPI committee in response to audit reports. An audit tool has been created to audit that nursing staff are competent hand hygiene (glove use), peri care (resident hand hygiene after peri care). Audits will be performed by DON or designee. 3 to 5 audits will be performed weekly. After 4 weeks of monitoring, demonstrating expectations are being met, monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months.	

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F 880	Continued From page 21 left the bathroom. 2. Observation on 10/1/24 at 11:12 a.m. of CNAs I and M assisting resident 11 with her toileting needs revealed: *The resident was transferred from her wheelchair to the toilet using a sit-to-stand mechanical lift. *After performing hand hygiene and placing clean gloves on her hands, CNA I removed the resident's wet incontinence brief and discarded it. -After resident 11 used the toilet, CNA I used those same gloved hands and cleansed the resident's peri-area using disposable wipes. -Upon using the final wipe, she wiped the resident from back to front wiping her rectal area up through the urethra (opening to the bladder) and her labial folds using the same soiled wipe. -With those same unclean gloved hands, CNA I placed a clean incontinence brief on resident 11 and pulled up the resident's pants. *She then removed those contaminated gloves and washed her hands. 3. Observation and interview on 10/2/24 at approximately 1:30 p.m. of CNAs I and N while assisting resident 28 revealed: *The resident was transferred from her wheelchair to the toilet using a sit-to-stand mechanical lift. *CNAs I and N stated they were trained upon hire and annually on peri-care using the electronic "Relias" training system. -They stated the nurses had performed audits on their peri-care skills several times in the last two years. *After toileting the resident, she was transferred into her room using the mechanical stand lift.	F 880		

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F 880	Continued From page 22 -CNA I washed her hands and applied clean gloves then performed the resident's peri-care using disposable wipes. -Upon performing the final wipe, she wiped the resident from back to front wiping the rectal area up through her urethra and labial folds using the same soiled wipe. -With those same contaminated gloved hands, CNA I placed a clean incontinence brief on resident 28. *CNA I then removed her gloves and without sanitizing her hands she: -Touched the resident's mechanical lift sling. -Adjusted the resident's clothing. -Applied a sweater to the resident's back and gave the resident her phone. -Combed the resident's hair. -Removed the sit-to-stand lift from the room and placed it in the hallway. *She then returned to the room and washed her hands while CNA N sanitized the mechanical stand lift. Interview on 10/3/24 at 12:30 p.m. with CNA I revealed: *She said she needed to wash her hands and apply clean gloves when entering the resident's room, when going from "dirty to fresh", and when exiting the room. -She was not aware she had not removed her unclean gloves, sanitized her hands, nor applied clean gloves after providing the resident's peri-care and before she placed the clean incontinence briefs on the residents observed above. *She verbally demonstrated how she normally performed peri-care by stating she wiped "up the front" when using the last wipe. -She stated, "I did not realize I was doing it	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING ______ B. WING ______	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONUMENT HEALTH STURGIS CARE CENTER	2140 JUNCTION AVENUE STURGIS, SD 57785

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F 880	Continued From page 23 incorrectly; I've always done it that way." Interview on 10/3/24 at 12:40 p.m. with DON/IP B regarding peri-care, hand hygiene, and glove use revealed: *It was her expectation that peri-care, hand hygiene, and glove use be performed according to facility policy, which was wiping from front to back, cleaning hands, and applying clean gloves when moving from a dirty procedure to a clean procedure. *She provided step-by-step education to staff on hand hygiene and glove use during a 4/11/24 'All Staff' meeting. *CNA I had been audited the week of 9/25/23 for peri-care and correctly demonstrated the procedure. -CNA I also completed a hand hygiene competency on 4/11/24 and correctly demonstrated hand hygiene and glove use at that time. *DON/IP B provided copies of the staff meeting, and the audits of CNA I, and all information was verified as accurate. Review of the provider's 5/2024 Pericare policy revealed: *"Guidelines:" -"g. ...For the female resident, spread the labia and be sure to wash from front to back." -"h. Don new gloves" -"i. Reapply a clean disposable product." *The policy had not included hand hygiene before application of clean gloves. Review of the provider's revised April 2024 Hand Hygiene policy revealed: *A. Indications for handwashing and alcohol-based hand rub use:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING ______ B. WING ______	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONUMENT HEALTH STURGIS CARE CENTER	**2140 JUNCTION AVENUE STURGIS, SD 57785**

(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 24	F 880		

-"14. Wash with soap and water after using a restroom."
*I. Other Aspects of Hand Hygiene:
-"4. Change gloves during patient/resident care if moving from a contaminated body site to a clean body site and perform hand hygiene."

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

PRINTED: 10/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING ______ B. WING ______	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONUMENT HEALTH STURGIS CARE CENTER	2140 JUNCTION AVENUE STURGIS, SD 57785

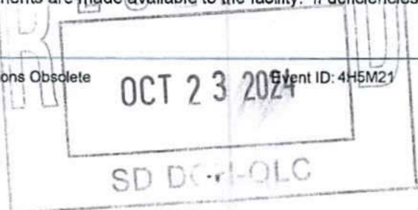
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 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 on 10/1/24. Monument Health Sturgis Care Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark C Schmidt

TITLE: President

(X6) DATE: 10/16/2024

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
	435102	A. BUILDING 01 - MASSA B. WING ______	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONUMENT HEALTH STURGIS CARE CENTER	**2140 JUNCTION AVENUE** **STURGIS, SD 57785**

(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 was conducted on 10/1/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Monument Health Sturgis Care Center building 1 (Massa) was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Schmidt
TITLE: President
(X6) DATE: 10-16-2024

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

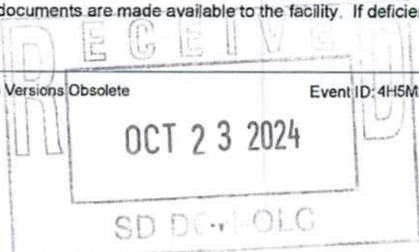
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING 02 - BERRY B. WING ______	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONUMENT HEALTH STURGIS CARE CENTER	2140 JUNCTION AVENUE STURGIS, SD 57785

(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 was conducted on 10/1/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Monument Health Sturgis Care Center building 2 (Berry) was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K232 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark C Schmidt	President	10-16-2024

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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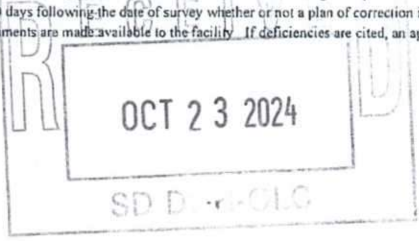
OCT 23 2024
SD DOH OLC

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435102	MULTIPLE CONSTRUCTION A. BUILDING: 02 - BERRY B. WING	DATE SURVEY COMPLETE: 10/1/2024
NAME OF PROVIDER OR SUPPLIER **MONUMENT HEALTH STURGIS CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **2140 JUNCTION AVENUE STURGIS, SD**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 232	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain unobstructed corridors in one randomly observed location (Berry unit nurse station). Findings include: 1. Observation on 10/1/24 at 9:43 a.m. in the Berry unit revealed two upholstered reclining chairs and a sitting chair with arms were situated in the egress corridor in front of the nurse station. The chairs were not restrained or in a designated area that was not in the path of egress. The reclining chairs would extend out about four feet from the wall into the path of egress. Interview with the director of plant operations at the time of the observation confirmed that finding. The deficiency had the potential to affect 100% of the occupants in the smoke compartment. Chairs were removed from corridor 10/3/24. All identified education was provided to all specified staff, no later than 11/15/24 or before their next scheduled shift if unable to receive educatioin prior to 11/15/24. To ensure the deficient practice does not reoccur, a monitoring system is established. Maintinance Director or designee will monitor 3X/ week for obstructons. Any issues will be addressed immediately. The audits will be discussed during Bi-month safety/QA meetings. QA Committee will determine if continued auditing is necessary once 100% complaince threshhold is achieved for two consecutive months.

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

The above isolated deficiencies pose no actual harm to the residents



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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
	435102	A. BUILDING 03 - ADMIN B. WING ______	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONUMENT HEALTH STURGIS CARE CENTER	2140 JUNCTION AVENUE STURGIS, SD 57785

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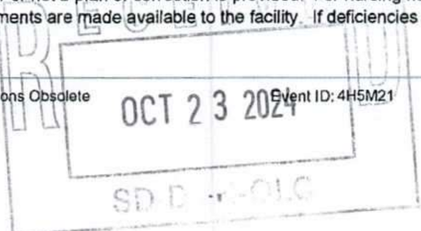
K 000	INITIAL COMMENTS A recertification survey was conducted on 10/1/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Monument Health Sturgis Care Center building 3 (Administration) was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark [illegible]
TITLE: President
(X6) DATE: 10-16-2024

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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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
	10693	A. BUILDING: ____ B. WING ____	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONUMENT HEALTH STURGIS CARE CENTER	**2140 JUNCTION AVENUE STURGIS, SD 57785**

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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 10/1/24 through 10/3/24. Monument Health Sturgis 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 10/1/24 through 10/3/24. Monument Health Sturgis Care Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark C Schmidt
TITLE: President
(X6) DATE: 10/23/2024

STATE FORM 6899 OVTS11 If continuation sheet 1 of 1