| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435032 | A. BUILDING _____ B. WING _____ | 08/24/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONUMENT HEALTH CUSTER CARE CENTER | 1065 MONTGOMERY ST CUSTER, SD 57730 |

| (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<br><br>Surveyor: 40788<br>A COVID-19 Focused Infection Control Survey was conducted by the South Dakota Department of Health Licensure and Certification Office on 8/24/20. Monument Health Custer Care Center was found not in compliance with the 42 CFR Part 483.80 infection control regulation: F880.<br><br>Monument Health Custer Care Center was found in compliance with the 42 CFR Part 483.73 infection control regulations: F882, F885, and F886.<br><br>Monument Health Custer Care Center was found in compliance with 42 CFR Part 483.73 related to E-0024(b)(6).<br><br>Total residents: 48 | F 000 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections | F 880 | **F880**<br>All current and future residents are potentially affected by the deficiency Infection Prevention and Control, F 880 for all identified observations.<br>The Policy "Personal Protective Equipment" was reviewed with no changes necessary.<br>The policy "Isolation precautions" was reviewed with no changes necessary.<br>The Policy "Hand Hygiene" was reviewed with no changes required.<br>Vestibules installed at the entrance/exit to each quarantine unit and Protocol created for Appropriate Vestibule Use, which includes Donning and Doffing practices, equipment cleaning, and keeping the vestibule and hallway doors shut.<br>All staff education completed no later than October 1, 2020, to include policy review and role responsibility with maintaining Vestibule securement, Donning and Doffing location, appropriate Donning and Doffing protocols, and hand hygiene. | 10/1/20 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Conner Fiscarelli* TITLE Senior Director, LTC Services (X6) DATE 9-11-20

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

RECEIVED
SEP 11 2020
SD DOH-OLC

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435032 | A. BUILDING _____ B. WING _____ | 08/24/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONUMENT HEALTH CUSTER CARE CENTER | 1065 MONTGOMERY ST CUSTER, SD 57730 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 1<br>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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. | F 880 | The deficiency for Hall 1 cited in observation 1 and 4 under F-880 was corrected by immediately removing the plastic barrier and closing the double doors on 8/24/2020. Additionally, the entire isolation unit (Hall 1 and Hall 3) was turned into a COVID-19 Positive-only unit by removing the designation of the three rooms identified in Observation 4 that were originally reserved for those residents that were suspected of having COVID-19 and being tested, but not yet confirmed as positive. Residents that are being tested are now placed on appropriate transmission-based precautions and held in their current room until results return. This is documented as an appropriate action as identified on page 10 of the facility COVID-19 mitigation plan. This was already part of the mitigation plan, thus no changes were necessary. These actions assisted in creating a distinct separation between the COVID-19 Isolation Unit (Halls 1 and 3) and the General Population Unit (Halls 2 and 4).<br><br>On 8/25/2020 facility received and installed a new Vestibule system, allowing for a distinct separation of the COVID unit and the general population while at the same time allowing for Doffing, use of hand hygiene station, and cleaning of equipment within the vestibule prior to exiting the COVID-19 Unit and entering the General Population. Vestibules were set up at the entrance/exit of Hall 1 and Hall 3 (two in total). PPE is donned outside of the vestibule on the general population unit prior to entering the vestibule and crossing into the isolation unit. A "do not enter, Red Zone" Sign was placed on each Vestibule location to ensure | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435032 | A. BUILDING _____ B. WING _____ | 08/24/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONUMENT HEALTH CUSTER CARE CENTER | 1065 MONTGOMERY ST CUSTER, SD 57730 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 2<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 40788<br>Based on observation, interview, review of special droplet/contact precautions signage, review of Centers for Disease Control (CDC) publications, and policy review, the provider failed to ensure infection control procedures and practices were followed for:<br>*Appropriate environmental controls to reduce or eliminate exposures to coronavirus disease 2019 (COVID-19) were implemented on one of two halls dedicated to caring for COVID-19 positive residents.<br>*Appropriate hand hygiene and personal protective equipment (PPE) use by two of two observed housekeepers (C and D) while cleaning COVID-19 positive residents' rooms.<br>Findings include:<br><br>1. Observation on 8/24/20 at 1:30 p.m. of hall 1 revealed:<br>*It was located near the nurses' station and a walk way used by all staff.<br>*There was a thin sheet of plastic that separated suspected COVID-19 positive residents' rooms 101 through 103 from positive COVID-19 rooms 104 through 114.<br>-That plastic was secured to the ceiling and was open all the way down the middle. | F 880 | that staff do not enter the vestibule without appropriate PPE donned, including N95. Protocol was created and education provided to all caregivers on or before October 1, 2020, regarding appropriate Vestibule protocol, to include PPE donning and doffing, as well as equipment cleaning.<br><br>This Vestibule system covers from ceiling to floor and from wall to wall. Each Vestibule is secured with a zipper in the center in order to allow caregivers to enter and exit the area. The other side of the vestibule is defined by the Door to the hallway. This door is to remain closed and the zipper is to remain shut at all times.<br><br>An audit tool was created to focus on Infection control to include Proper closure of Vestibule. An audit (audit tool) will be completed a minimum of three times a week on each vestibule by Director of Nursing or designee to review proper infection control practice. Audit tool will also include observing appropriate donning and doffing PPE by staff a minimum of three times per week. These audit results/findings will be provided and reviewed to QAPI at a minimum monthly by the DON or their designee, but no less than quarterly. These audits will continue for a minimum of 3 months at which point decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee.<br><br>(continue on next page) | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435032 | A. BUILDING _____ B. WING _____ | 08/24/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONUMENT HEALTH CUSTER CARE CENTER | 1065 MONTGOMERY ST CUSTER, SD 57730 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 3<br>-One side of that plastic was taped half way down the south wall.<br>-The opposite side of that plastic was not secured to the north wall.<br>-Multiple strips of tape held that plastic together in one piece.<br>*The bottom of the plastic was not secured to the floor.<br>-It moved back and forth because of airflow.<br><br>2. Continued observation of hall 1 between 1:30 p.m. and 2:00 p.m. and again at 2:30 p.m. revealed four of the five occupied residents' room doors had been open.<br><br>3a. Observation on 8/24/20 at 1:35 p.m. of housekeeper C cleaning the first observed occupied COVID-19 positive resident room on hall 1 revealed:<br>*He wore gloves, a surgical mask, and a face shield when he entered that room.<br>*He exited that room after approximately three minutes of cleaning.<br>-He stated, "We gotta gown in every room."<br>*Without removing his used gloves and performing hand hygiene he retrieved a clean gown from the PPE cart, put it on, and returned to that room to finish cleaning.<br><br>b. Continued observation at 1:40 p.m. of housekeepers D and C in a second observed occupied COVID-19 positive room on that same hall revealed:<br>*Without performing hand hygiene housekeeper D put on a gown and gloves before he entered that room.<br>*Without performing hand hygiene housekeeper C put on gloves then pushed down accumulated trash inside a large garbage receptacle with his | F 880 | The deficiency cited under F880, Infection Prevention and Control, Observations 2 and 4, regarding open doors to resident rooms has the potential to impact all residents on Halls 1 and 3, as well as any residents on any future Isolation Units. This deficiency was corrected immediately by closing all doors on the COVID unit. Verbal Education was provided to all staff in reference to closing of all resident doors on the COVID unit for decreasing risk of spread of the virus with a follow up written education on 9/3/2020, but no later than October 1, 2020 to all caregivers that work on the isolation unit including direct care staff and ancillary departments such as housekeeping and plant ops. A separate communication binder was provided to the COVID unit to ensure that the caregivers on that unit have access to any important information or changes to protocol on the isolation unit. Signage was placed on each resident door stating "doors must remain closed at all times."<br>An audit tool was created to focus on Infection control to include closure of resident room doors. An audit (audit tool) will be completed a minimum of three times a week on each Covid unit by the Director of Nursing or designee to review compliance of infection control practices, ensuring that resident room doors on the unit remain shut at all times. These audit results/findings will be provided and reviewed to QAPI at a minimum monthly by the DON or their designee, but no less than quarterly. These audits will continue for a minimum of 3 months, at which point decision to continue/ discontinue/reduce frequency of the audit (audit tool) will be made by QAPI Committee. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435032 | A. BUILDING _____ B. WING _____ | 08/24/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONUMENT HEALTH CUSTER CARE CENTER | 1065 MONTGOMERY ST CUSTER, SD 57730 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 4<br>gloved hands.<br>*He immediately put on a gown and entered the same room and began cleaning.<br><br>c. Continued observation at 1:50 p.m. of housekeepers D and C in a third observed occupied COVID-19 room revealed:<br>*Housekeeper C exited that room after it was cleaned, and removed his gown and gloves.<br>*He adjusted his surgical mask under his face shield with that ungloved hand while holding a sack of garbage collected from that room.<br>*Without performing hand hygiene he put on new gloves and a new gown before entering the next resident room.<br>*Housekeeper D removed his gown and gloves after cleaning that same room.<br>*He adjusted his surgical mask under his face shield with his ungloved hand and performed hand hygiene.<br><br>4. Interview on 8/24/20 at 1:00 p.m. with director of nursing (DON) A regarding hall 1 revealed:<br>*The double-doors that led into that hall had been kept open.<br>*The three residents' rooms inside those doors had been designated for residents with suspected COVID-19.<br>-Those rooms had been unoccupied.<br>*The remainder of rooms down that hall had been for COVID-19 positive residents.<br>-There were seven residents in five of those rooms.<br>*The plastic referred to earlier separated those distinct sections of that hall.<br><br>Interview on 8/24/20 at 2:45 p.m. with DON A regarding COVID-19 positive residents' rooms revealed: | F 880 | The deficiency cited under F880, Infection Prevention and Control, Observations 3 and 4, regarding appropriate usage, donning, and doffing of PPE by housekeeping staff has the potential to impact all residents in the facility.<br><br>The deficiency regarding inappropriate usage of PPE was corrected through education from Environmental Services Supervisor to her housekeeping caregivers, including PPE donning and doffing, hand hygiene and the importance of not touching their surgical mask unless they have first performed hand hygiene. This education was provided no later than October 1, 2020. Each room on the COVID-19 Isolation Unit has a red strip on the door to indicate COVID Positive status of residents and indicate the need to wear all appropriate PPE when providing care for the resident, including N95, surgical mask, face shield, gowns and gloves. Each door in the Isolation Unit has a teal colored sign showing PPE to be used in each room. Each room on the Isolation Unit has a donning and doffing signage on the door.<br><br>A donning and doffing competency was created to monitor appropriate process. The Environmental Services Director will complete the competency with each caregiver in this department no later than October 1, 2020.<br><br>(Continue on next page) | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435032 | A. BUILDING _____ B. WING _____ | 08/24/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONUMENT HEALTH CUSTER CARE CENTER | 1065 MONTGOMERY ST CUSTER, SD 57730 |

| (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 5<br>*It was her expectation that staff followed the signage instructions posted outside those residents' rooms for hand hygiene and PPE use.<br>*Resident room doors were not required to be closed on that unit.<br>-Some residents preferred to have their doors open.<br><br>Interview at that same time with senior director of long term care services B regarding the plastic that separated suspected COVID-19 residents from positive COVID-19 residents on hall 1 revealed:<br>*He confirmed that plastic had not created an effective barrier between those units.<br>*He agreed that double-doors leading into hall 1 should have been closed.<br>*He stated he understood the COVID-19 residents' rooms should have been closed.<br><br>Telephone interview on 8/26/20 at 1:00 p.m. with infection control nurse E regarding hall one revealed she:<br>*Confirmed the plastic barrier referred to above was ineffective.<br>*Stated the double-doors and residents' room doors should have been closed.<br>-Those environmental controls had not been implemented.<br><br>Review of the undated COVID-19 Risk Mitigation Plan revealed:<br>*COVID-19 designated units (page 6 of 13):<br>-"2. Doors to the unit/room should be shut."<br>-"3. All room doors should remain shut on that unit to the extent that resident safety allows."<br><br>Review of the updated 7/15/20 CDC publication Interim Infection Prevention and Control | F 880 | An audit tool was created to focus on Infection control to include Proper Personal Protective Equipment usage with quarantine units to focus on donning and doffing. An audit (audit tool) will be completed a minimum of three times a week on each COVID-19 Unit by the Environmental Services Director or designee. These audit results/findings will be provided and reviewed to QAPI at a minimum monthly by the DON or their designee, but no less than quarterly. These audits will continue for a minimum of 3 months at which point decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee.<br><br>All staff education for all actions taken to correct the deficiencies found in all observation under F880 was completed no later than October 1, 2020, to include policy review and role responsibility with maintaining Vestibule securement, Donning and Doffing location, appropriate Donning and Doffing protocols, and hand hygiene. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435032 | A. BUILDING _____ B. WING _____ | 08/24/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONUMENT HEALTH CUSTER CARE CENTER | 1065 MONTGOMERY ST CUSTER, SD 57730 |

| (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 6<br>Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic revealed:<br>*Page 5 of 13:<br>-Optimize the use of engineering controls to reduce or eliminate exposures by shielding healthcare providers and other patients (residents) from infected individuals.<br>-Examples of engineering controls include physical barriers and dedicated pathways.<br><br>Review of the undated Special Droplet/Contact Precautions signage outside resident rooms on hall one revealed:<br>*Instructions for staff entering resident rooms.<br>-Those instructions indicated staff entering those rooms must sanitize or wash hands, wear gown, wear gloves, wear eye protection, and wear a surgical mask.<br>-Additional instructions included sanitizing or washing hands with soap and water when exiting the room.<br><br>Review of the revised 6/25/20 CDC publication Preparing for COVID-19 in Nursing Homes revealed:<br>*Page 5 of 9:<br>-"Care must be taken to avoid touching the respirator, facemask, or eye protection. If this must occur, HCP [healthcare provider] should perform hand hygiene immediately after touching PPE to prevent contaminating themselves or others." | F 880 | | |