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	435032	A. BUILDING _____ B. WING _____	07/01/2021

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

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F 000	INITIAL COMMENTS Surveyor: 40053 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/29/21 through 7/1/21. Monument Health Custer Care Center was found not in compliance with the following requirements: F550, F758, F812, F842, F849, F883, and F909.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550	The resident rights deficiency related to findings for Resident 38 and cited in F550 (Resident Rights/Exercise of Rights) are unable to be corrected. However, Resident 38 was a "queued" diner at the time of the findings. Resident 38's careplan was reviewed and updated by Director of Nursing (DON) on 7/19/21 to change Resident 38's dining status to "Assisted" in order to better meet her dining needs. All residents have the potential to be impacted by this deficiencies. On or prior to August 20, 2021, all residents will have their dining status reviewed and updated as appropriate by DON, Certified Dietary Manager (CDM) or designee(s). On 7/19/21, DON reviewed and revised the facility "Dignity" policy to reflect dignity during meal service. The policy was updated to reflect the need to have staff presence for assisted and queued diners prior to meal being served to the resident(s) to ensure the meal is served	8/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Sr. Director, LTC (X6) DATE 7-21-21

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F 550 Continued From page 1
or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Surveyor: 40788
Based on observation, interview, and policy review, the provider failed to ensure one of one sampled resident (38) received necessary assistance she required in a respectful manner during one of two observed meals. Findings include:

1. Observation on 6/29/21 between 12:20 p.m. and 12:52 p.m. of resident 38 revealed:
*She was brought into the dining room in her wheelchair by an unidentified caregiver who placed her in front of a long dining table then left the dining room.
-Her meal was immediately placed in front of her by kitchen staff.
-She kept her hands in her lap and made no attempts to feed herself throughout that observation period.
*There was one other resident at the opposite end of that same table.
*Activity assistant J sat directly behind resident 38 feeding another resident.
-A second staff was at the opposite end of the

F 550 while it is still at an appropriate temperature. Other components of dignity during meal service were already reflected in the policy prior to the review and updates on 7/19/21.

On or prior to 8/20/21, education will be provided by DON or designee to Nursing, CNA, and Dietary departments. Education will focus on dignity as relates to the dining experience, including but not limited to being attentive to resident needs; ensuring that queued and assisted residents are being fed when the food is still at appropriate temperature; communicating with the residents when assisting with their dining. Education will also include ensuring that queued and assisted residents are served their meals when staff are fully available to assist to ensure that meals are still hot when the resident begins eating.

Any caregivers that were assigned the education and did not complete it prior to 8/20/21, will be required to complete the education prior to their next worked shift.

Starting no later than 8/20/21, audit will be conducted 3 to 5 times per week by CDM or Designee using an audit tool. The Audit tool will focus on the resident dining experience. This audit will include monitoring timeliness of trays delivered to queued and assisted dining residents,

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F 550	Continued From page 2 dining room assisting a resident with their meal. *Between 12:20 p.m. and 12:40 p.m. no verbal cueing or physical assistance was offered to resident 38 with her meal. -Throughout that time caregivers brought residents in and out of the dining room and kitchen staff were in and out of that dining room serving meals. *At 12:40 p.m. registered nurse (RN) G leaned over, rested her left forearm in front of and on top of resident 38's table and asked her, "Are you going to eat?" -She fed her a spoonful of food from the plate before leaving the dining room. *At 12:50 p.m. RN G transported a resident into the dining room placing them across from resident 38. -She said to resident 38, "gotta keep eating" and pushed the plate closer to her then exited the dining room. *At 12:51 p.m. as she passed by resident 38 certified nurse aide K asked her, "Are you going to have lunch?" Observation and interview on 6/29/21 at 12:52 p.m. with activity assistant J helping resident 38 with her meal revealed: *Activity assistant J sat down beside the resident and provided verbal cues and physical assistance to help her eat. *The individual pieces of chicken on her plate had dried and begun to curl. -The vegetable servings had a congealed appearance. *Activity assistant J agreed the food was probably cold, but had not offered her a freshly plated meal. -Said the meal should not have been served unless someone had been available to sit next to	F 550	and aspects of a dignified dining experience, including but not limited to: ensuring that residents that need queueing and assistance have a caregiver present once their meal is served and that the caregiver is meeting both their care and social needs as identified above in the education. Starting no later than 8/20/21, audit results will be reported by the CDM or designee to facility QAPI meeting on a monthly, but no less than quarterly basis. Audits will be continued for a minimum of 3 months, at which point the QAPI committee will determine whether to continue, discontinue, or reduce frequency.	

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F 550	Continued From page 3	F 550		

her and help her.
*The resident had recent medication changes and required more staff assistance for things like eating.

Observation and interview on 6/30/21 at 11:30 a.m. with medication aide M in the dining room with resident 38 revealed she:
*Sat by her to determine how much assistance she had required to eat her meal.
-The resident had recent medication changes that affected her ability to feed herself as she previously had done.
*Remained seated next to her throughout the meal service providing verbal cues, alternately feeding her and placing food on her fork to encourage her to feed herself.

Interview on 7/1/21 at 12:40 p.m. with cook L regarding resident 38's level of required dining assistance revealed:
*Her Dietary Recommendations card had indicated she required "Nursing Prompt."
-That meant she could be seated and served her meal but required a caregiver to provide verbal prompts to encourage her intake.

Interview on 7/1/21 at 1:00 p.m. with director of nursing B regarding observations referred to above revealed she:
*Confirmed the decline in resident 38's ability to feed herself.
*Had expected once she had been served her meal that staff remained with her to determine how much of their assistance was required to help her eat.

Review of the revised August 2016 Dignity policy revealed the following related to the dining

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F 550	Continued From page 4 experience: *Provide adequate supervision and assistance to residents. *Ensure interactions during mealtimes are meaningful to individual residents. *Develop an environment that ensures direct care staff can assist feeding residents comfortably. -Avoid standing over residents as they are assisted with dining.	F 550		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758	The deficiency found in F758 (Free from Unnecessary Psychotropic Meds/PRN Use) for Resident 30 has been corrected on or prior to 7/24/21 by having the resident's attending provider review appropriateness of the PRN psychotropic and determine to add a duration to the order with rationale. Communication from Provider was conducted by DON or designee. The deficiency found in F758 (Free from Unnecessary Psychotropic Meds/PRN Use) for Resident 38 has been corrected on or prior to 7/24/21 by having the resident's attending provider review appropriateness of the PRN psychotropic and determine to add a duration to the order with rationale. Communication from Provider was conducted by DON or designee.	8/20/21

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F 758	Continued From page 5 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on record review, interview, and policy review, the provider failed to ensure a physician included in the order a duration of time for an as needed (prn) psychotropic medication for two of three sampled residents (30 and 38) who received a prn psychotropic medication. Findings include: 1. Review of resident 30's medical record revealed an order written 6/1/21 for ativan 0.5 millligrams (mg) every eight hours as needed for severe anxiety leading to agitation. Review of resident 30's June 2021 medication administration record for prn ativan use revealed she had received it one time between 6/1/21 and	F 758	The deficiency related to F758 has the potential to impact all residents with PRN psychotropic medications. By no later than 8/20/21, all residents with PRN psychotropic medications will have their PRN psychotropic medications reviewed by DON, Pharmacy consultant or designee(s). As appropriate, DON or designee will communicate with the attending provider(s) to have the PRN reviewed for discontinuation or to add a duration with a rationale. At the time of the survey, facility did not have a PRN psychotropic medication policy. By no later than 8/20/21, DON or designee will create a psychotropic drug policy to include guidance regarding the use of PRN psychotropic medication. This policy will include writing the PRN order for 14 days unless rationale is otherwise documented and a duration is included. Prior to 8/20/21, a process will be implemented to have any PRN psychotropic order that is received to be entered by DON or designee as a reminder on the resident's TAR to notify the physician of need for reassessment.	

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F 758	Continued From page 6 6/30/21. Review of her June 2021 physician order summary that included that ativan order revealed: *It had been reviewed and signed by her physician during a 6/8/21 resident visit. -No duration of time for that prn ativan had been indicated. Review of consultant pharmacist F's undated June 2021 Note to Attending Physician/Prescriber regarding resident 30's monthly medication review revealed he requested that ativan order was limited to fourteen days unless a rationale and duration of time for continued prn use was identified. 2. Review of resident 38's medical record revealed two orders written on 5/12/2. One order for ativan1.0 mg every eight hours as needed for anxiety and a second order for ativan 1.0 mg prn thirty to sixty minutes prior to bath to control agitated behavior related to anxiety. Review of resident 38's medication administration records revealed: *Between 5/1/21 and 5/31/21 she had received the every eight hours prn ativan two times. -She had received the prn ativan prior to bathing two times. *Between 6/1/21 and 6/30/21 she had not received the every eight hours prn ativan. -She had received the prn ativan prior to bathing once. Review of resident 38's June 2021 physician order summary that included that ativan order revealed: *It had been reviewed and signed by her	F 758	On or prior to 8/20/21, education will be provided by DON or designee to nurses and attending providers. Education will include the need to write the PRN order for 14 days unless rationale is otherwise documented and a duration is included. Nurses will be responsible for checking these requirements when entering orders in the Electronic Medical Records. Communication by Nurses to providers or Nursing Management will be required when discrepancies between the order and policy are identified. Any caregivers that were assigned the education and did not complete it prior to 8/20/21, will be required to complete the education prior to their next worked shift. Starting no later than 8/20/21, audit will be conducted by DON or designee on a weekly basis using an audit tool. The audit will include appropriate duration and documentation in medical record for ordering/continuation of PRN psychotropic medications. To conduct the audit, DON or designee will run a weekly psychotropic report out of Point Click Care (PCC). DON or designee will review all PRN psychotropic medications that will have started during the week of the most current audit. Appropriate follow-up with the ordering provider will be conducted by DON or designee to correct any discrepancies between the written order and facility policy.	

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F 758	Continued From page 7 physician during a 6/22/21 resident visit without indicating a duration of time needed for those orders. Review of consultant pharmacist F's undated June 2021 Note to Attending Physician/Prescriber regarding resident 38's monthly medication review revealed he requested those ativan orders were limited to fourteen days unless a rationale and duration of time for continued prn use was identified. Interview on 7/1/21 at 11:58 a.m. and 1:17 p.m. with director of nursing (DON) B regarding prn psychotropic medications revealed: *There was no internal process for tracking the duration or rationale for use of prn psychotropic medications. *The time between consultant pharmacist F completing his monthly Notes to Attending Physician/Prescriber and the time she received those Notes had taken a minimum of a few weeks to receive. *Upon receipt, she had printed each of those Notes and placed them in individual physician folders at the nurses' station. *Those physicians reviewed and acted on those Notes during nursing home rounds. -Physicians rounded as frequently as twice weekly or less than monthly unless contacted by the provider. *Agreed the current process had not supported notifying and securing required physician orders related to prn psychotropic medications within the required fourteen day time frame. A Psychotropic Drug policy was requested of DON B on 7/1/21 at 1:15 p.m. She stated there was no policy.	F 758	Starting no later than 8/20/21, audit results will be reported by the DON or designee to facility QAPI meeting on a monthly, but no less than quarterly basis. Audits will be continued for a minimum of 3 months, at which point the QAPI committee will determine whether to continue, discontinue, or reduce frequency.	

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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 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: Surveyor: 42558 Based on observation, interview, log review, and policy review, the provider failed to ensure the kitchen had stored, prepared, and monitored food processes for the forty residents that included: *Maintaining a clean and sanitary kitchen. *Monitoring and logging food temperatures at each meal. Findings include: 1. Observation on 6/29/21 at 11:33 a.m. through 12:15 p.m. of the facility kitchen revealed: *Four freezers located in a dry storage area. -The first freezer contained a tray of pre-scooped ice cream in individual dishes that had been loosely covered with undated plastic wrap.	F 812	No residents were identified in the deficiency cited in F812 (Food Procurement Store/Prepare/Serve-Sanitary). All residents have the potential to be impacted by the deficiency cited in F812. To immediately address the deficiencies in observations 1 and 2 in F812 a full cleaning of the kitchen was performed by CDM and dietary staff. The cleaning was orchestrated by CDM and her designees. Additionally, CDM began weekly monitoring of all food temperature logs and kitchen cleaning logs prior to 7/24/21. On or prior to 7/24/21, the CDM held interim educational huddles to address the cleaning log and food temperature log processes. On 7/19/21, CDM added the task of spot cleaning kitchen walls to the cleaning log, to include above stove and steamer. The rest of the items in the deficiency were already on the cleaning log. The temperature log was reviewed by the CDM prior to 8/20/21, with no needed changes identified. Prior to 8/20/21, CDM or designee reviewed the following policies with no necessary policy revisions identified as it relates to the deficiencies cited in F812: "Sanitization Policy" and "Proper Testing of Food Temperatures."	8/20/21

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F 812	Continued From page 9 --The ice cream had visible ice crystals on the surface. -The second freezer exterior door handle had been sticky to touch with a build-up of an unidentified substance on the inside surface of the handle. -The inside of the fourth freezer had an approximate quarter inch layer of ice to the bottom surface with small yellow particles on top of the ice. -There were multiple hand print smudges around the exterior periphery of all four freezer doors. *A sliding glass door refrigerator located across from the serving steam table had held drinks for the upcoming meal. -The interior of the sliding glass door had been streaked with random yellow and red dried substances. *A hand washing station to the left of the serving table had particles of a dried green blue substance to the back wall above the sink. *The painted brick wall behind the gas range had multiple brown streaks extending from top to bottom. *The metal front of the hot line steam serving table had been splattered with white and tan streaks of unidentified dried food substances. -The corners of the exterior steam table were corroded with a dried yellow substance. *The cold line serving table had a serving ladle laying on the plating ledge with fresh cottage cheese running onto the ledge. -This ledge also had various food crumbs and a smeared yellow substance on the surface. 2. Observation and interview on 6/29/21 at 11:45 a.m. with cook D revealed: *He wiped down the above mentioned plating ledge and removed the serving ladle upon	F 812	By no later than 8/20/21, CDM or designee will conduct a mandatory in-service for dietary employees. In-service will include, but not be limited to: a review of the findings in the deficiencies cited in F812; "Sanitization" and "Proper Testing of Food Temperatures" Policies; review of cleaning and temperature log responsibilities. Any caregivers that were assigned the education and did not complete it prior to 8/20/21, will be required to complete the education prior to their next worked shift. By no later than 8/20/21, CDM or designee will begin weekly audits using an audit tool. The audit will focus on completion/accuracy percentage of cleaning logs and food temperature logs. Starting no later than 8/20/21, audit results will be reported by the CDM or designee to facility QAPI meeting on a monthly, but no less than quarterly basis. Audits will be continued for a minimum of 3 months, at which point the QAPI committee will determine whether to continue, discontinue, or reduce frequency.	

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F 812	Continued From page 10	F 812		

noticing this surveyor's observance.
*When asked to see his food temperature log for the meal currently being served he stated the log would be in the dietary manager's office.
-Stated he normally wrote the temperature of each food on top of the tinfoil covers to the food containers that had been delivered to the hospital and assisted living.

Interview and kitchen walk through on 6/29/21 at 11:47 a.m. with dietary manager C revealed she:
*Agreed the above mentioned areas of the kitchen needed further cleaning.
-Had a daily log of kitchen cleaning duties each shift had been expected to perform and log their initials.
-Provided a weekly cleaning log for the current week and had been unable to locate any prior logs.
*Expected the cooks to monitor and log food temperatures when the food came out of the oven at each meal.
-Informed meal temperatures had not been consistently placed into the food temping log.
*Had been responsible for monitoring the overall condition of the kitchen and ensuring the logs had been completed.
-Identified her need to get back into routine and her staff needed to do a better job of recording the meal temperature logs.

Interview on 7/1/21 at 10:13 a.m. with the Senior Director of Long Term Care A revealed he:
*Expected food would be temped and logged at each meal and the dietary department would follow regulatory guidance on the temping of meals.
*Expected the kitchen would be cleaned according to facility policy.

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F 812	Continued From page 11 *"The cleaning and logging of food temperatures are an opportunity for improvement in process." *Had not been aware of any food borne illnesses amongst the residents. Review of the provider's previous month of meal temperature logs revealed from 5/22/21 to 6/19/21 there had been fifty-eight out of eighty-seven meal temperatures not recorded. Review of the provider's 1/25/16 Proper Testing of Food Temperatures policy indicated the food would be temped prior to serving the meals and the temperatures would be recorded on the food temperature log. Review of the provider's revised October 2008 MED-PASS, Inc. (Incorporated) Sanitization Policy revealed: *All food service areas would be maintained in a clean and sanitary manner. *All equipment and food contact surfaces would be washed to remove or completely loosen soils by manual or mechanical means and sanitized. *Refrigerators and freezers would be cleaned monthly and as spills occurred. *The food services manager would be responsible for scheduling staff for regular cleaning of kitchen and dining areas.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842	DON immediately corrected the deficiency cited in F842 (Resident Records – Identifiable Information) for Resident 25 on 6/30/2021 by printing all Hospice notes provided via email and filing in resident Hospice binder.	8/20/21

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F 842	Continued From page 12 agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained	F 842	All current and future residents are potentially affected by the deficiency regarding: Resident Records-Identifiable Information. All residents receiving Hospice services, to include immediately upon hospice admission and thereafter, the hospice Nurse will hand deliver weekly progress notes to the DON or designee. These records will be reviewed and integrated into the resident care plan by DON or designee. Once integrated, these records will be filed into the residents Hospice Binder for nursing review by the Heath Unit Clerk (HUC) or designee. Access to the electronic medical records system will be provided to the Hospice Nurse(s) to document a progress note on the day of the visit. The Hospice Agreement was reviewed. The policy "Care Plan timing and Revision" Policy was revised to include integration of Hospice careplan into EMR and into the Hospice Binder. On or prior to 8/20/21, education will be provided by DON or designee to nurses, including hospice nurses. Education will include but is not limited to: where to find hospice information and documentation, careplan recommendations, PCC progress note education for hospice nurse(s).	

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F 842	Continued From page 13 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on interview, record review, and Hospice Agreement review, the provider failed to have a system in place for obtaining necessary documentation to ensure complete and accurate resident medical records for one of two sampled residents (25) who received hospice services through one of one hospice agency. Findings include: 1. Review of resident 25's care record revealed: *She admitted to hospice care on 6/11/21. *Between 6/11/21 and 6/30/21 there had been no progress notes related to hospice visits written by the provider during that time. Review on 6/29/21 of the hospice agency notebook at the nurses' station for resident 25	F 842	Any caregivers that were assigned the education and did not complete it prior to 8/20/21, will be required to complete the education prior to their next worked shift. An audit (audit Tool) was created to focus on the timeliness of filing records into the medical record to include hospice care plan integration for Hospice residents. An audit tool to review the filing of medical records and integration of hospice careplan into the resident chart/facility careplan process will be completed by the Director of Nursing or designee on Hospice Residents (3-5 residents, unless fewer residents are on hospice services) on a weekly basis and results/findings reported to the committee by the DON or designee and will be reviewed in QAPI monthly, but no less than quarterly. These audits will continue for a minimum of 3 months (quarterly QAPI meeting cycles) at which point decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee.	

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F 842	Continued From page 14 revealed pre-printed information regarding how or when to contact the hospice agency and a medication list dated 6/11/21. Interview on 6/29/21 at 1:20 p.m. with registered nurse (RN) G and medication aide H regarding hospice communication revealed: *They received resident specific hospice information verbally from hospice staff at the time of their hospice visit. -RN G indicated a progress note was entered in the resident's care record by staff regarding that encounter. *They had thought hospice agency documentation was entered in the hospice's electronic medical record (EMR) system. Telephone interview on 6/30/21 at 9:40 a.m. with hospice RN I regarding hospice communication revealed: *Hospice staff notified nursing staff by phone of their planned hospice visits and discussed the hospice resident's status at that time. *Hospice documentation was completed in their EMR at the time of the hospice visit. Interview on 6/30/21 at 10:00 a.m. with director of nursing B regarding communication between the provider and the hospice agency revealed she: *Thought staff had read only access to the hospice agency's EMR, but may have been unaware of that. *Received copies of hospice documentation for resident 25 on a weekly basis from the hospice director, but had not been filed it in that resident's care record. *Agreed resident 25's care record had not included complete and accessible hospice information.	F 842		

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F 842	Continued From page 15 -It was her expectation that the care record had reflected ongoing information exchanges between the agency and the provider in order to respond to changing status and needs of that hospice resident. Review of the 6/19/13 signed Hospice Agreement revealed: *Section 4 cooperation in Patient (Resident) Care Information: -"The Home (Nursing Home) and Hospice agrees to cooperate in the facilitation of open and clear communication in order that the needs of patients are addressed and met 24 hours per day. Such communication shall include the sharing of all relevant records and other information regarding a patient, pursuant to any limits under applicable law."	F 842		
F 849 SS=E	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following	F 849	DON corrected the deficiency cited in F849 (Hospice Services) for Resident 4 on 7/19/2021 by updating all goals and interventions for hospice services in the resident's careplan in alignment with Hospice documentation/recommendations and careplan. DON corrected the deficiency cited in F849 (Hospice Services) for Resident 25 on 7/4/2021 by updating all goals and interventions for hospice services in the resident's careplan in alignment with Hospice documentation/recommendations and careplan.	8/20/21

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F 849	Continued From page 16 requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board	F 849	All current and future residents are potentially affected by the deficiency regarding: Hospice Services. All residents receiving Hospice services, to include immediately upon hospice admission and thereafter, the hospice Nurse will hand deliver weekly progress notes to the DON or designee. These records will be reviewed and integrated into the resident care plan by DON or designee. Once integrated, these records will be filed into the residents Hospice Binder for nursing review by the Heath Unit Clerk (HUC) or designee. Access to the electronic medical records system will be provided to the Hospice Nurse(s) to document a progress note on the day of the visit. The Hospice Agreement was reviewed. The policy "Care Plan timing and Revision" Policy was revised to include integration of Hospice careplan into EMR and into the Hospice Binder. On or prior to 8/20/21, education will be provided by DON or designee to nurses, including hospice nurses. Education will include but is not limited to: where to find hospice information and documentation, careplan recommendations, PCC progress note education for hospice nurse(s).	

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F 849	Continued From page 17 care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written	F 849	Any caregivers that were assigned the education and did not complete it prior to 8/20/21, will be required to complete the education prior to their next worked shift. An audit (audit Tool) was created to focus on the timeliness of filing records into the medical record to include hospice care plan integration for Hospice residents. An audit tool to review the filing of medical records and integration of hospice careplan into the resident chart/facility careplan process will be completed by the Director of Nursing or designee on Hospice Residents (3-5 residents, unless fewer residents are on hospice services) on a weekly basis and results/findings reported to the committee by the DON or designee and will be reviewed in QAPI monthly, but no less than quarterly. These audits will continue for a minimum of 3 months (quarterly QAPI meeting cycles) at which point decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee.	

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F 849	Continued From page 18	F 849		

agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

The designated interdisciplinary team member is responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.

(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

(iv) Obtaining the following information from the hospice:

(A) The most recent hospice plan of care specific to each patient.

(B) Hospice election form.

(C) Physician certification and recertification of the terminal illness specific to each patient.

(D) Names and contact information for hospice personnel involved in hospice care of each patient.

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F 849	Continued From page 19 (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on interview, record review, and hospice agreement review, the provider failed to ensure integrated plans of care had been developed for two of two sampled residents (4 and 25) receiving hospice services. Findings include: 1. Record review of resident 4 revealed: *On 3/23/21 a physicians order for hospice. *On 3/26/21 a Minimum Data Set significant change. Review of her 6/29/21 care plan revealed: *"Focus: -I have been admitted to Hospice. -Date initiated 4/1/21." *"Goal:	F 849		

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-I will accept hospice care and remain comfortable.
*Interventions:"
-"I qualify for essential/compassionate care visits with my daughter."
-"I will be scheduled for daily 1:1's with activity staff."
*There had been no other documentation related to hospice and the care she was to have received at the facility.

Surveyor: 40788
2. Review of resident 25's care record revealed she had been admitted to hospice care on 6/11/21.

Review of resident 25's care plan last revised on 6/29/21 revealed:
*A hospice goal was added to her care plan on that date.
-No interventions had identified what hospice services were provided, how often hospice services were to have been in the facility, or how hospice care was used.

Telephone interview on 6/30/21 at 9:40 a.m. with registered nurse I regarding the hospice care plan revealed it should have been in the resident's record, but she was not certain it was.

Interview on 6/30/21 at 10:00 a.m. and on 7/1/21 at 1:50 p.m. with director of nursing B regarding hospice care plans revealed she:
*Had been responsible for revising resident 4 and 25's care plans after hospice services had begun.
*Had received weekly hospice documentation from the hospice director that included hospice care plans.
-Had not printed or filed that documentation in

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F 849	Continued From page 21 resident 4 or 25's care records. *Confirmed the provider's hospice plans of care had not been developed in coordination with the hospice agency but should have been. Review of the revised 3/2019 Care plan Development-Baseline and Comprehensive policy revealed: *"The comprehensive care plan will be updated at least quarterly in correlation with required assessments, and with any significant change to resident status and/or cares." Review of the 6/19/13 signed Hospice Agreement revealed: *Section 2A regarding the Hospice Plan: -Developed at the time an eligible resident was admitted into hospice. -Included the management and palliation of the resident's terminal illness, a detailed description of the scope and frequency of hospice services, specified services and supplies related to the resident's terminal illness that were provided by the hospice agency. -A copy of that plan of care was furnished to the provider at the time of that resident's hospice admission.	F 849		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883	The deficiency found in F883 (Influenza and Pneumococcal Immunizations) were remedied by DON for Residents 8 and 27. Review of orders for resident 8 completed and order placed in attending physician folder for review and signature for Pneumovax immunization. This will be completed no later than 7/20/2021.	8/20/21

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F 883	Continued From page 22 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883	Review of resident 27's medical record and communication with resident's POA on 7/19/21 determined resident had received the Pneumovax immunization at another facility. These records were requested. Documentation completed in progress notes in resident medical record on 7/19/21 by DON. All current and future residents are potentially affected by the deficiency regarding: Influenza and Pneumovax immunizations. All residents currently in the facility will have their immunization records reviewed and orders discussed with attending physician no later than 8/20/21. On admission, all residents will be asked immunization status on the nursing admission assessment. A flow sheet was created and is kept up by the DON or designee for tracking prior to 7/24/21. On or prior to 8/20/21, education will be provided by DON or designee to nursing staff. Education will include but is not limited to: Admission process for immunization status, order entry to Treatment Administration Record (TAR), Verification of order process, and documentation into EMR.	

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 _____	07/01/2021

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

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F 883	Continued From page 23 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on record review, interview, and policy review, the provider failed to ensure two of five randomly sampled residents (8 and 27) had documented pneumonia vaccination administration or refusal in their care records. Findings include: Review of the randomly sampled residents' care records above revealed: *Resident 8's admission date was 4/6/21. *Resident 27's admission date was 2/23/21. *There was no documental pneumonia vaccination administration or refusal in any of those records. Interview on 6/30/21 at 10:20 a.m. with director of nursing B revealed: *Pneumonia vaccination information was documented on admission paperwork completed by a resident's physician prior to or immediately following that resident's admission. -She had contacted the physician for a pneumonia vaccination order if that vaccination information was unknown or unable to be obtained. *Vaccination refusals were documented in the resident record. *She had known the residents referred to above had no pneumonia vaccination information in their care records, but had not had time to follow-up on	F 883	**Any caregivers that were assigned the education and did not complete it prior to 8/20/21, will be required to complete the education prior to their next worked shift.** An audit (audit Tool) was created to focus on the Influenza and Pneumovax immunizations timeliness and documentation in the medical record. An audit (audit tool) will be completed to review the Influenza **and Pneumovax immunizations** for current and future residents on a weekly basis by the Director of Nursing or designee and results/findings reported to the committee by the DON or designee and will be reviewed in QAPI monthly, but no less than quarterly. These audits will continue for a minimum of 3 months (quarterly QAPI meeting cycles) at which point decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee.	

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F 883	Continued From page 24 that. -It had been her responsibility to ensure that had been followed up on in a timely manner. Review of the October 2019 revised Pneumococcal Vaccination policy revealed: *Guidelines: -"A. Prior to or upon admission, residents will be assessed for eligibility to received the Pneumovax (pneumococcal vaccine), and when indicated, will be offered the vaccination within thirty [30] days of admission to the facility unless medically contraindicated or the resident has already been immunized."	F 883		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, and policy review, the provider failed to assess side rails on three of twelve sampled residents' beds (6, 20, and 33) in a census of 71 routinely as a part of a preventative maintenance program to ensure those side rails were in good working order and safe from possible resident entrapment. Findings include: 1. Observations made on 6/29/21 between 11:15	F 909	Deficiencies cited in F909 (Resident Bed) for Residents 6, 20, and 33 were corrected on 7/19/2021 by completing an assessment focusing on the working condition of the repositioning bar(s), clip placement, and entrapment risk. This assessment was documented into the residents EMR under progress notes. All current and future residents are potentially affected by the deficiency regarding: Resident Bed. All current and future residents will have an assessment completed on admission, quarterly, and as needed regarding repositioning bar use. DON or designee will review every resident bed currently with a repositioning bar by no later than 8/20/21, to include documentation in their medical record. The "Repositioning Bar" Policy was reviewed by DON prior to 8/20/21. No needed changes were identified.	8/20/21

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F 909	Continued From page 25 a.m. and 5:30 p.m. of the above residents' rooms revealed quarter length side rails on one or both sides of those beds. Interview on 6/30/21 at 11:05 a.m. with maintenance mechanic E regarding side rails revealed he: *Confirmed side rails had been checked for proper fit if a new resident bed had required side rail installation. *There was no preventative maintenance schedule or re-evaluation of those side rails by an employee of the maintenance department after the initial installation. *Relied on caregivers to submit a work order to the maintenance department to assess and correct any reported side rail concerns. Interview on 6/30/21 at 3:00 p.m. with director of nursing B regarding side rails revealed: *Rails were assessed to ensure they were in good working order and posed no entrapment risk when quarterly side rail assessments had been completed for those residents who used them. -Agreed that assessment had documented the rationale for the continued need of a side rail, but had not documented whether or not the side rail had been assessed to ensure it was in good working order and safe from possible resident entrapment. *There were a total of nine residents who had side rails on their beds. Review of the revised November 2020 Repositioning Bars policy revealed: *Guidelines -"1. All residents will be assessed for the use of a repositioning bar upon admission or re-entry to	F 909	By no later than 8/20/21, the repositioning bar assessment will be revised by DON or designee to reflect the addition of assessing the working order and secure placement of repositioning bar, clip use, and entrapment risk. On or prior to 8/20/21, education will be provided by DON or designee to nursing staff. Education will include but is not limited to: entrapment risks of repositioning bar; work order process; how to determine if repositioning bar is loose or secure. Any caregivers that were assigned the education and did not complete it prior to 8/20/21, will be required to complete the education prior to their next worked shift. An audit (audit Tool) was created to focus on the working order of repositioning bar, gap of mattress if any, and any entrapment risk with use of repositioning bar. An audit (audit tool) will be completed to review current use of repositioning bar (s) with focus on but not limited to working order, slippage of mattress, clip use, and entrapment risk on a weekly basis by the Director of Nursing or designee and results/findings reported to the committee by the DON or designee and will be reviewed in QAPI monthly, but no less than quarterly. These audits will continue for a minimum of 3 months (quarterly QAPI meeting cycles) at which point decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee.	

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F 909	Continued From page 26 the facility and then quarterly thereafter." -"4. ...check for any gaps between mattress and device, check to see that mattress does not compress or slip when bed is occupied potentially creating a gap, mattress clips should be installed if mattress slips causing any gap between mattress and device. Documentation of these steps will be addressed in the Nursing portion of the Reposition Bar Assessment/Screen."	F 909		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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 _____	06/29/2021

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

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E 000	Initial Comments Surveyor: 18087 A recertification health survey for compliance with all Federal, State, and local Emergency Preparedness requirements was conducted on 6/29/21. Monument Health Custer Care Center was found in compliance with 42 CFR Part 483.73 requirements.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Sr. Director, LTC (X6) DATE 7-21-21

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
	435032	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2021**

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MONUMENT HEALTH CUSTER CARE CENTER	**1065 MONTGOMERY ST CUSTER, SD 57730**

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the life safety code (LSC) (2012 existing health care occupancy) was conducted on 6/29/21. Monument Health Custer Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K345, K712, K918, and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation, interview, and plan review, the provider failed to ensure staff were familiar with the provider's fire drill procedures (closing corridor doors and checking the door for the fire location). Findings include:	K 712	The deficiency identified will be corrected by conducting additional training sessions and drills to meet or exceed the minimum requirements, to increase staff knowledge of code red situations. The new employee education training will include a life safety session to focus on code red education. The Basic Fire Instructions form will be updated to cover specific areas of the drills that have been short of the expectation. It will also target specific areas of topic such as, proper evacuation procedure, staff responsibilities and processes. An aggregated report will be communicated to the scheduled Safety / QAPI committee (on a monthly not less than quarterly basis) by the Plant Operations Manager or a designee to assure staff can demonstrate the proper techniques and procedures.	8/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Sr. Director, LTC (X6) DATE 7-21-21

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
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	435032	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/29/2021

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K 712	Continued From page 1 1. Observation on 6/29/21 at 3:15 p.m. revealed the fire alarm was sounded to initiate a drill for a simulated fire in resident room 402. Only one staff person responded to the simulated fire location, the remaining staff were in other wings or the center core area by the nurses station. Two staff person were sent to the fire location by the charge nurse, but only one arrived at the fire location. Four residents were in the corridor of the 400 wing at the time of the fire alarm sounding. At no time were these residents taken to a place of refuge up to the point of the all clear being sounded at the end of the drill. Resident room corridor doors 401, 403, 404, 405, 406, 407, 408, and 410 were open throughout the fire drill. The lone respondent to the fire drill had a fire extinguisher but did not perform an acceptable closed door check for heat (used the front of her hand and opened the door without checking the metal handle for heat). She then proceeded to enter the room without a backup responder in accompaniment. The provider's Basic Fire Instructions did not specify to isolate the fire and close all corridor doors prior to attempting to extinguish the fire. It also did not specify to evacuate residents from the corridor to areas of refuge (into enclosed rooms or beyond smoke barrier doors) prior to attempting to extinguish the fire. Interview with the operations manager at the time of the observation confirmed those findings. The deficiency had the potential to affect 100% of the occupants.	K 712	It shall be the departments leaders responsibility to assure that their staff are attending training sessions and understanding responsibilities. All residents have the potential to be affected by a failure to meet these requirements.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435032	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING	DATE SURVEY COMPLETE: **6/29/2021**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on document review and interview, the provider failed to maintain one of one fire alarm system as required. Findings include: 1. Record review at 2:45 p.m. on 6/29/21 revealed the annual fire alarm inspection report dated 2/16/21 did not list sensitivities for the ionization-type smoke detectors. Ref: 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11 3. Interview with the operations manager at the time of the record review confirmed those findings. He stated the contractor who provided the testing only confirmed a pass or fail condition. He added the fire alarm panel was an older model not an 'intelligent' model which did not have the capability to show the sensitivities of the smoke detectors. The deficiency affected 100% of the occupants.
K 918	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 918	Continued From Page 1 damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to document generator battery conductivity monthly (no documentation for 2020 and 2021). Findings include: 1. Record review on 6/29/21 at 2:15 p.m. revealed there was not any documentation of the battery conductivity in the monthly maintenance logs for the generator for calendar year 2020 and 2021. Interview with the maintenance supervisor at 3:15 p.m. on 6/29/21 revealed the generator had a maintenance-free battery installed and it could not be tested for specific gravity. He stated he was unaware of the monthly battery conductivity documentation requirement. The deficiency affected 100% of the building occupants.
K 923	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the facility failed to protect medical gas storage as required.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 923	Continued From Page 2 Combustible items were stored on racks within five feet of the oxygen cylinders in the 200 wing oxygen transfilling room. Findings include: At 3:00 p.m. on 6/29/21 combustible materials were found to be stored adjacent to and within five feet of oxygen cylinders in the 200 wing oxygen transfilling room. The minimum five feet of separation between combustibles and oxygen storage was not maintained as required in this area. The deficiency affected one of four smoke compartments.

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
	10610 S	A. BUILDING: _____ B. WING _____	07/01/2021

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S 000	Compliance/Noncompliance Statement Surveyor: 40053 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/29/21 through 7/1/21. Monument Health Custer Care Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Sr. Director, LTC (X6) DATE 7-21-24

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