STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/17/23 through 7/20/23. Monument Health Sturgis Care Center was found not in compliance with the following requirements: F550, F658, F661, F726, F849, and F880.	F 000		
F 550 SS=E	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 or resident of the United States.	F 550	F550 Corrective Action: 1.For the identification of and lack of a homelike environment, was corrected by educating all licensed and non-licensed staff on the facility assisted dining policy on 8/10/23. The policy includes: the television should not be turned on during the meal, music may be played at a low level, try to make the mealtime as pleasant and restful as possible. Resident 12 who was affected by this area of identification, discharged from facility on 8/7/23. 2.For the identification of and lack of conversations between residents and staff occurring in both dining rooms, was corrected by educating all licensed and non-licensed staff on the facility assisted dining policy on 8/10/23. This policy includes do not visit with coworkers while assisting resident in dining room. Conversations should be directed to the resident. 3 For the identification of and lack of dignity not being maintained for residents 32 and 49 by covering the urine collection systems, was corrected by covering their urine collection systems with dignity bags. This was completed on 7/20/23. 2 Identification of Others All current and future residents are potentially affected by the deficiency of not providing a homelike environment during mealtime, not providing conversations between residents and staff during mealtimes, and not providing dignity by covering urine collection systems with dignity bags	9/1/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] President 8/15/23

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
AUG 15 2023
SD DOH-OLC

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 §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: Based on observation, interview and policy review, the provider failed to ensure the following: *A homelike environment had been observed and staff assistance was provided in one of two dining rooms (Massa) during three of three observed mealtimes. *Conversations between residents and staff had occured in one of two dining rooms (Berry) during one of one observed mealtime. *Dignity had been maintained for two of four sampled residents (32 and 49) by covering the urine collection systems. Findings include: 1. Observation on 7/17/23 from 11:45 a.m. through 1:09 p.m. in the Massa dining room revealed: *Twenty residents were in the dining room and resident 12 was sleeping in her wheelchair. *Television (TV) was on, and country music was playing. *Certified medication aide (CMA) I was at the medication cart watching the residents and had not been passing any medications. *Four unidentified certified nursing assistants	F 550	Assisted Dining policy reviewed with CNA's, Licensed Nurses, Activities caregivers, dietary and housekeeping staff. Foley Catheter Care policy reviewed with CNA's and Licensed Nurses. Education provided to all Licensed Nurses and CNA's where dignity bags are stored in facility. DON or designee will ensure all facility staff responsible for the assigned task(s) have received education/training with documentation by 9/1/23 or before their next scheduled shift if unable to receive education prior to 9/1/23 Additional dignity bags were ordered on 8/9/23 to ensure all current and future residents who need urine collection system dignity bags had them if the bag became soiled or damaged. The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies and procedures for the above identified areas. 3. Monitoring: Audit tool has been created to focus on the assisting dining is being completed per facility policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 (CNAs) were serving lunch to the residents. -CNAs would place the food in front of the residents then walked away with out speaking to the residents. -Resident 12 was awakened to eat her lunch. -After the twenty residents were served in the dining room, the CNAs started delivering residen room trays, with one CNA that stayed in the dining room to assist a resident with their meal. *CMA I stayed in the dining room by the medication cart. *Two of the residents (2, 12) were not eating their meals and received no verbal or physical assistance from the CNA or CMA. -Resident 12 had fallen back asleep with a fork in her hand. -After five minutes resident 2 started to eat her meal. *Sixteen minutes later two CNAs came back from delivering room trays and assisted resident 12 with her meal. -A CNA sat next to the resident and placed some fruit on a spoon and offered it to the resident. --The resident refused the fruit. --The CNA had not offered or assisted the resident with any of the pasta and left the table after one attempt of assisting the resident with the fruit. -The resident had been attempting to use her fork to eat the pasta, but the pasta was sliding around the plate. *Eight minutes later resident 12 was sleeping again, with the fork in her hand. *CMA I had not offered the above mentioned residents any food or fluids until questioned about who should have been assisting those residents. -CMA I then asked resident 12 if she was still hungry which resident nodded her head yes. -CMA I then assisted resident 12 by holding a cup	F 550	The assisted dining audit tool will continue for a minimum of 6 months. (i. e. two 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. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional educational opportunities will be directed by QAPI committee in response to audit reports. Audit tool has been created to audit that assisted dining policy is being followed per facility policy. Audits will be performed by DON or designee; 3 to 5 audits will be performed weekly. After 4 weeks of monitoring demonstrating expectations are being met monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months. Audit tool has been created to focus on foley catheter care being completed per facility policy. The foley catheter care audit tool will continue for a minimum of 6 months. (i. e. two 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. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional educational opportunities will be directed by QAPI committee in response to audit reports. Audit tool has been created to focus on foley catheter care being completed per facility policy. Audits will be performed by DON or designee; 3 to 5 audits will be performed weekly. After 4 weeks of monitoring demonstrating expectations are being met monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3	F 550		

with her chocolate supplement for the resident to drink.
--The resident refused to eat the pasta or the fruit that CMA I had offered her.
-CMA I left three minutes later and returned with a straw for the resident to drink her juice with and then left.
*Ten minutes later an unidentified CNA sat down next to resident 12 and offered her a bite of the pasta and the resident refused, the CNA put the fork down and left the table.
--The unidentified CNA had not offered to reheat the resident's meal or offer any substitutes for the meal.
*Resident 12 then grabbed her fork and attempted again to pick up the pasta, but the pasta fell to the floor.
-Two minutes later the resident was falling back asleep holding the fork in her hand.
-Two minutes after the resident fell asleep an unidentified kitchen worker came and took the residents fork out of her hand and removed her tray from the table.

Observation on 7/18/23 from 8:20 a.m. to 8:45 a.m. in the Massa dining room revealed:
*Eighteen residents were in the dining room.
*TV was on, a hip-hop song was playing loudly with shirtless men and women wearing bikini's rolling around together in the sand drinking alcohol.
*An unidentified CNA was assisting resident 12 with her meal.
*CMA I was at the medication cart watching the residents.
*Three unidentified CNAs were talking to each other at a table while one of them was sitting on a chair next to a resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 Interview on 7/18/23 at 9:10 a.m. with CMA I regarding the Massa dining room observation revealed: *She was in the dining room to monitor for choking, and chart supplement intakes. *She was cardiopulmonary resuscitation (CPR) certified and she was to have always remained in the dining room during meal service. *She agreed the hip-hop song was not appropriate for the residents but she could not change the TV channel as that was decided by the activities department. Interview on 7/18/23 at 9:15 a.m. with activity assistant H regarding the video on the TV revealed she: *Agreed the hip-hop video was inappropriate for the residents. *Stated, "Sometimes the residents request what the younger generation listened to." *Should have asked the more alert residents what they would have liked to listen to. *Agreed some videos were not appropriate for the residents during meals. Interview on 7/18/23 at 1:10 p.m. with CNA G about the Massa dining room observation revealed: *She was watching the residents and would assist those residents that were not eating or drinking their supplements. -She would encourage the residents to eat their meals and to drink their supplements. -If a resident was not eating their meal or drinking their supplements then she would have had another CNA attempt to get the resident to eat. *She agreed other food items could have been offered when a resident was not eating.	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5	F 550		

2. Observation on 7/18/23 between 11:50 a.m. and 12:40 p.m. in the Berry dining room revealed:
*At 11:50 a.m. nine random residents had been seated in the dining room for the noon meal.
-There was one table of four residents, three tables with a single resident seated at each of them, and one table with two residents.
*Meals had been plated starting at 12:10 p.m. by dietary staff Y.
*Between two and five staff persons (CNA V, CNA W, CMA J, restorative aide (RA)/CMA P, and RA X) were waiting in front of the serving counter with their backs toward the residents in the dining room waiting for that first plated meal.
-There was no conversation between staff and residents from the time residents had been brought to the dining room and the plating of meals started.
*Staff served residents their meal trays and assisted them with any meal-related needs.
-They returned to the serving counter and with their backs faced toward the residents waited behind the staff lined up in front of them for another meal tray to serve.
*During the observation time referred to above the only staff and resident conversations that occurred were the following:
-At 12:20 p.m. CNA V verbally prompted resident 47 to eat.
-At 12:23 p.m. CMA J offered resident 26 a meal substitution.
-At 12:26 p.m. An unidentified resident requested staff assistance for her tablemate to have staff open her ice cream cup.
-At 12:27 p.m. CMA J offered resident 47 a Kleenex to wipe his nose.
-At 12:28 p.m. RA W walked around the dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6	F 550		

room and would briefly interact with residents at each table.
-At 12:32 p.m. RA X verbally prompted an unidentified resident to eat.

Interview on 7/18/23 at 12:35 p.m. with CMA J regarding the dining room meal observation revealed she:
*Usually waited until residents had nearly finished their meal before she had interacted with them.
-Had not wanted to interrupt them during their meal.

Interview on 7/20/23 at 12:50 p.m. with director of nursing (DON) B regarding the observations made in the Massa and Berry dining rooms revealed:
*CNAs and CMAs who passed meal trays were expected to have offered and provided the necessary assistance each resident required to have eaten their meal as independently as possible.
*CNAs and CMAs were expected to interact with residents throughout each meal service and to provide needed encouragement to eat their meals and drink their fluids and/or supplements.
*CNAs and CMAs should have offered a meal substitution to any resident who had not eaten or had minimally eaten their meal.
*Television was a distraction and was not expected to have been turned on during the resident mealtimes.
*CNA or CMA presence in the dining room during mealtimes was expected to occur at all times.

Review of the January 2021 revised Assisted Dining room policy revealed:
*"The purpose of assisted dining is to ensure that residents receive required nourishment with as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 7 much enjoyment as possible." -"C. Prepare resident at table including clothing protector/napkin if needed." -"F. Resident dining experience: --1. Do not visit with coworkers while assisting resident in the dining room. Conversation should be directed to the resident. --2. Televisions should not be turned on during the meal. Music may be played at a low level. --3. Try to make the meal time as pleasant and restful as possible for the resident." 3. Observation on 7/18/23 at 11:33 a.m. and observation and interview on 7/19/23 at 9:40 a.m. with resident 32 in his room revealed: *His uncovered urine collection bag had hung towards the foot of his bed. -It had been visible to any resident or visitor walking by his room. *He stated that sometimes the urine bag was covered and placed in another bag but not consistently. Observations of resident 49 on 7/17/23 at 12:15 p.m., on 7/18/23 at 12:05 p.m. in the dining room, and on 7/18/23 at 3:00 p.m. in his room revealed he: *Required the use of a urine collection bag. -The urine collection bag was uncovered during the above observations. Interview on 7/19/23 at 9:45 a.m. with CNA V and CNA W outside resident 32's room after they had emptied his uncovered urine collection bag revealed: *The resident had his own blue bag that his urine collection bag was placed in to maintain his dignity but was only used when he was outside of his room.	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 8 *There had been similar bags for other residents like resident 49 who had a urine collection bag but they were unable to find any of those bags to cover the urine collection bags in the central supply room. Interview on 7/20/23 at 10:35 a.m. with DON B revealed she expected all residents that required a urine collection bag to have had them covered inside of another bag regardless of whether the resident was in or out of their room in order have maintained their dignity. Review of the revised February 2019 Foley Catheter Care policy revealed: "G. When the resident is in bed or seated, assure collecting bag is off the floor and covered for dignity and hygiene."	F 550		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to adhere to professional standards of practice for the following: *Post-dialysis care per the provider's policy for one of one sampled resident (37). *The use of a physician ordered pain assessment scale prior to the administration of narcotic pain medication for one of one sampled resident (49). Findings include:	F 658	F658 Corrective Action: 1.For the identification of and lack of post-dialysis care per the provider's policy for resident 37, was corrected by editing the time on the order to check thrill and bruit on access site daily to completing this order twice a day. This is to ensure resident 37 access site is being assessed after dialysis per dialysis care policy. This was corrected on 7/24/23. 2.For the identification of and lack of not using a physician ordered pain assessment scale prior to administration of a narcotic pain medication for resident 49, was corrected by clarifying the narcotic pain medication order with resident 49's primary provider. Morphine orders for resident 49 were edited per this resident's pain needs and the instructions for mild/moderate pain were removed from pain medication orders. This was corrected on 7/19/23.	9/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 9 1. Observation on 7/17/23 at 3:00 p.m. of resident 37 revealed: *She had returned from dialysis and was walking independently around the facility. -The dialysis access site on her right arm was covered and had no visible signs of bleeding. Review of resident 37's care record revealed: *A physician's order summary reviewed on 7/17/23 included an order to"check thrill and bruit daily" (a rumbling sound that was heard and a rumbling sensation that was felt at the dialysis access site). -Her July 2023 medication administration record (MAR) indicated that physician order was expected to have been completed by the nursing staff at 8:00 a.m. daily. Interview on 7/18/23 at 5:00 p.m. with licensed practical nurse (LPN) F regarding resident 37 revealed she: *Had checked the resident's thrill and bruit daily at 8:00 a.m. according to the physician's order on the MAR. -That occured prior to dialysis. *Was able to "visualize" the resident's access site following dialysis for any unusual bleeding, thrill, and bruit. -Confirmed that the thrill and bruit would not have been assessed without a stethoscope and physically touching the resident. Interview on 7/19/23 at 11:15 a.m. with director of nursing (DON) B regarding resident 37 revealed she: *The physician's order should also have included instructions to have checked the resident's thrill and bruit after she had returned from dialysis.	F 658	Identification of Others: All current and future residents with dialysis needs are potentially affected by the deficiency of not providing post dialysis care. Dialysis care policy reviewed with all licensed nurses. All current and future residents are potentially affected by the deficiency of not using a physician ordered pain assessment scale for narcotic medication with range orders. Reeducation to all licensed nurses and medical director that unless necessary, range orders should be clarified and edited to not include a range. Reeducation to all licensed nurses and medical director that if a range order for pain medication is necessary it must include an ordered pain assessment within the instructions of the order. All current resident's orders with narcotic medications audited and if needed corrected to ensure they had a physician ordered pain assessment scale to refer to (if indicated) prior to narcotic administration was completed 8/16/23. DON or designee will ensure all facility staff responsible for the assigned task(s) have received education/training with documentation by 9/1/23 or before their next scheduled shift if unable to receive education prior to 9/1/23 The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies and procedures for the above identified areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 10 -Confirmed that was best nursing practice and that was the facility's policy. Review of the "20/21 Long Term Care Nursing: Dialysis Competency" that DON B had identified as the provider's Dialysis policy revealed: Post-Dialysis Care: "Assess access site for bruit, thrill, exudate, signs of infection, bleeding." 2. Observation and interview on 7/18/23 at 3:00 p.m. with infection control (IC) nurse (E) and LPN (F) during wound care in resident 49's room revealed he: *Had prostate cancer that had spread to his bones and was receiving hospice services. *Had dysphasia making it difficult to have made his needs known. -Used unintelligible sounds, pointed to things, and shook his head yes and no to try to have made his needs known. Review on 7/18/23 of resident 49's physician order summary revealed: *A 4/26/23 physician's order: Morphine sulfate oral solution. "Give 0.25 by mouth every 3 hrs [hours] PRN [as needed] for mild pain/dyspnea and give 0.5 ml by mouth every 3 hrs PRN for moderate pain/dyspnea." -That physician order had been noted and entered into the resident's electronic medical record by nurse supervisors C and D. Review of resident 49's treatment administration records (TAR) revealed: *May 2023 TAR: -0.25 ml of morphine had been administered one time (5/7/23) for mild pain rated as a "6." -0.5 ml of morphine had been administered five times (5/7/23, 5/8/23, 5/12/23, 5/14/23, and	F 658	Monitoring: Audit tool has been created to focus on residents who are receiving dialysis care, are receiving dialysis care per facility dialysis care policy. The dialysis care audit tool will continue for a minimum of 6 months. (i. e. two 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. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional educational opportunities will be directed by QAPI committee in response to audit reports. Audit tool has been created to focus on residents who are receiving dialysis care, are receiving dialysis care per facility dialysis care policy. Audits will be performed by DON or designee; 3 to 5 audits will be performed weekly. After 4 weeks of monitoring demonstrating expectations are being met monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months. Audit tool has been created to ensure residents with narcotic medications do not have range orders unless necessary. If range orders are necessary, they must include an ordered pain assessment within the instructions of the order.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 11 5/28/23) for moderate pain rated between "4" and "8." *June 2023 TAR: -.25 ml of morphine had not been administered that month for mild pain. -0.5 ml of morphine had been administered five times (6/1/23, 6/13/23, 6/19/23, 6/22/23, and 6/26/23) for moderate pain levels rated between "3" and "7." Interview on 7/19/23 at 9:30 a.m. with LPN F regarding the numerical pain ratings for resident 49 and his May 2023 and June 2023 TARs revealed: *The physician's morphine orders had not included numerical pain scale parameters that had defined what constituted "mild" and "moderate" pain. *She completed a PAINAD (Pain Assessment in Advanced Dementia) assessment tool to determine a numerical pain value for the resident based on a pain score between 0 and 10. -A pain score between 1 and 6 was "mild" and a pain score over 6 was "moderate" pain. *She was unable to provide a copy of the PAINAD tool she referred to or any references to support the PAINAD scoring system that she had used. Review of the PAINAD assessment tool revealed: *It was an observational tool with numerical equivalents for each of five behavioral items. -Each of those items was scored between 0 to 2 for a maximum score of 10. *Scoring guidelines: -1 to 3=mild pain. -4 to 6=moderate pain. -7 to 10=severe pain. Interview on 7/20/23 at 11:30 a.m. with DON B	F 658	The narcotic order review audit tool will continue for a minimum of 6 months. (i. e. two 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. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional educational opportunities will be directed by QAPI committee in response to audit reports. Audit tool has been created to ensure residents with narcotic medications do not have range orders unless necessary. If range orders are necessary, they must include an ordered pain assessment within the instructions of the order. Audits will be performed by DON or designee; 3 to 5 audits will be performed weekly. After 4 weeks of monitoring demonstrating expectations are being met monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 12 regarding resident 49's PRN morphine order revealed: *Nursing supervisors C and D should have completed the following: -Established with the ordering physician a pain scale to have been used in conjunction with the morphine order. -Identified what score based on that scale constituted "mild" pain and what score based on that scale constituted "moderate" pain. -Entered that physician's order information on resident 49's TAR. *LPN F had not used the PAINAD assessment tool correctly. *There was no consistency between the amount of morphine that had been administered to the resident according to the pain level because there was no pain scale to reference.	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and	F 661	F661 Corrective Action: 1.For the identification of and lack of ensuring resident 50 had a discharge summary completed. This was corrected by IDT entering in additional details about her discharge into discharge summary assessment and progress notes. This was corrected on 8/10/23. 2.Identification of Others: All current and future residents are potentially affected by the deficiency of not completing discharge summary. Discharge policy reviewed with all licensed nurses. All discharge paperwork will be electronically filed into each resident's EMR within an acceptable time frame after discharge.	9/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 13 over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of one closed record sampled resident (50) had a discharge summary completed after she was discharged from the facility. Findings include: 1. Review of resident 50's closed record revealed: *Her admission date was 7/19/22 and the discharge date was 4/27/23. *A 4/27/23 progress note: "Resident discharged at 1130 [11:30 a.m.]" -There was no documentation where she had been discharged to, how she was transferred, if there was any resident-specific documentation that was sent with her, if there was any hand-off communication between the sending and receiving facility, and if any medications had been sent with the resident at the time of discharge. *An unsigned 4/27/23 discharge summary that had included the resident's admission date, the discharge date, the reason for discharge, and an activity narrative summary. -The remainder of that discharge summary had not been completed with the following information: a location where the resident had discharged to, nursing, therapy, social services,	F 661	All new licensed nurses will be educated on the discharge policy upon hire. DON or designee will ensure all facility staff responsible for the assigned task(s) have received education/training with documentation by 9/1/23 or before their next scheduled shift if unable to receive education prior to 9/1/23 The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies and procedures for the above identified areas. Monitoring: Audit tool has been created to focus on ensuring residents who have discharged from facility have a discharge summary completed per facility discharge policy. The discharge summary audit tool will continue for a minimum of 6 months. (i. e. two 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. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional educational opportunities will be directed by QAPI committee in response to audit reports. Audit tool has been created to ensure residents who have discharged from the facility have a discharge summary completed per facility discharge policy. Audits will be performed by DON or designee; 3 to 5 audits will be performed weekly. After 4 weeks of monitoring demonstrating expectations are being met monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 14	F 661		

and dietary narrative summaries related to the resident's nursing home stay.
*A completed medication destruction log that had accounted for remaining controlled medications the resident had taken during her stay at the facility.

Interview on 7/20/23 at 1:00 p.m. with director of nursing B revealed:
*The 4/27/23 progress note and discharge summary referred to above resident was incomplete.
-She had expected documentation to have included: a description of the resident's current functional status, an interdisciplinary review of her stay at the nursing home, any records that had been sent with the resident, who had transported the resident at discharge, what belongings had been sent with the resident, any resident-specific information that was faxed to the receiving facility or that was included with the completed discharge summary and given to the admitting facility, and confirmation that handoff report occurred.

Review of the revised 1/16/23 Discharge policy revealed:
*"G. If transfer to another facility will call and give nurse to nurse as well as fill out the transfer form and send with or fax to new facility."
*"H. Document in electronic record any education given as well as:
-1. Time of discharge;
-2. With whom they were discharged (via vehicle, etc.);
-3. Resident status at time of discharge; and
-4. Documentation of nurse to nurse must also be documented in electronic record."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726 F 726 SS=F	Continued From page 15 Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure there was licensed nursing oversight and supervision to ensure the following:	F 726 F 726	F726 Corrective Action: 1.For the identification of and lack of provider failing to ensure there was licensed nursing oversight and supervision to ensure that CMA's in the facility had received initial and annual CMA competencies and they are competent in the following areas: What medications to crush and that it is not within the CMAs scope of practice to calculate doses of medication or to determine when medications are crushed. This was corrected by completing individual CMA competencies will all current CMAs in the facility. Medication/treatment administration general guidelines policy and crushing medication policies reviewed with CMAs in the facility. Additional education also reviewed with CMA's in the facility: Scope practice of CMA, only crush resident's medications if they have an order in their EMR to do so and not to use cheat sheets, medication cassettes indicate if medications can be crushed or not. The following above education and competencies were completed on 8/10/23. Resident 18 was discharged from the facility on 8/7/23. Resident 32'sLactulose order was clarified and revised to give scheduled doses at scheduled times. Resident 47 received an order to please crush any meds that may be crushed for this resident when requested order on 8/9/23.	9/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 16 *One of one CMA (I) had not crushed and administered a delayed seizure medication to one of one sampled resident (18) to prevent a medication error from having occurred. *One of one CMA (I) had received initial medication administration orientation. *One of one CMA (K) had not calculated a Lactulose medication dose for one of one sampled resident (32). *One of one CMA (J) had not decided whether or not it was safe for one of one sampled resident (47) to have taken his medications whole without crushing them. *One of one CMA (J) had received annual medication administration education or had completed a medication administration competency. Findings include: 1. Observation and interview on 7/19/23 at 11:00 a.m. of CMA I during the lunch medication pass in the Massa dining room revealed: *Resident 18 had a medication order for divalproex sodium (Depakote) DR (delayed-release) 250 milligrams (mg) one tablet by mouth three times daily. -The medication administration record (MAR) indicated it was given for a seizure disorder. *She crushed delayed-release medication and mixed it with pudding prior to administering it to the resident. -Stated, "They [CMA's] told me to crush her [resident 18's] medications because she can't swallow whole pills." *Verified there were no directions listed on resident 18's MAR that her medications could or could not be crushed. -She had memorized which residents had crushed medications from the temporary CMA	F 726	2. Identification of Others: All current and future residents are potentially affected by the deficiency of failing to ensure there was licensed nursing oversight and supervision to ensure that CMA's in the facility had received initial and annual CMA competencies to ensure they are competent in the following areas: What medications to crush and that it is not within the CMAs scope of practice to calculate doses of medication or to determine when medications are crushed. Medication/treatment administration general guidelines policy and crushing medication policies reviewed with CMAs and Licensed nurses in the facility. Additional education also reviewed with CMA's and Licensed nurses in the facility: Scope practice of CMA, only crush resident's medications if they have an order in their EMR to do so and not to use cheat sheets, medication cassettes indicate if medications can be crushed or not. Orders to crush medications requested from medical director for all current residents within the facility who need/request their medications to be crushed on 8/9/23. Facility will ensure that all CMA's complete a CMA competency on hire and annually by a licensed nurse. DON or designee will ensure all facility staff responsible for the assigned task(s) have received education/training with documentation by 9/1/23 or before their next scheduled shift if unable to receive education prior to 9/1/23 The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies and procedures for the above identified areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 17 who had trained her. -That CMA no longer worked at the facility. *She would ask the nurse in charge if she had any questions about a resident's medication. -She had not asked the nurse about crushing resident 18's delayed-release medication. *She had close to four years of CMA experience and started working for the provider a little over a month ago. -She denied having any licensed professional observe her during the medications pass. Interview on 7/19/23 at 11:15 a.m. with licensed practical nurse (LPN) K, who was working as the nurse for Massa unit, regarding the above observation and interview with CMA I revealed: *The CMAs would pass all routine medications. *There was a list of residents who had their medications crushed that was located in the Massa medication cart's narcotic log binder. *She was not aware resident 18's medications were being crushed by the CMA. *Stated, "Delayed-release tablets should not be crushed and the provider should be contacted for an alternative form of medication, such as a liquid." -She expected the CMAs to come to her with any medication questions. *She thought nurse supervisor D had assigned the CMA orientation training. *The CMA's were trained by CMA's. *She was unsure if the CMAs were given medication pass competencies at the facility. Review of the 6/28/23 Massa Unit list of resident names that were located in the narcotic binder revealed resident 18's medications as "Crushed." It had not indicated what medications should not have been crushed.	F 726	Monitoring: Audit tool has been created to focus on ensuring CMA's within the facility are competent when passing medications. The CMA audit tool will continue for a minimum of 6 months. (i. e. two 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. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional educational opportunities will be directed by QAPI committee in response to audit reports. Audit tool has been created to audit that CMAs are competent with medication administration. Audits will be performed by DON or designee; 3 to 5 audits will be performed weekly. After 4 weeks of monitoring demonstrating expectations are being met monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 18	F 726		

Interview on 7/19/23 at 11:20 a.m. with nurse supervisor D regarding the above medication pass observation revealed:
*She had been employed by the facility as a nurse supervisor since November of 2022.
*The charge nurses and the CMA's were responsible for filling out the sheet in the narcotic book for the residents that were to have crushed medications.
-"It is just a 'cheat sheet' for them to follow, it is not an official form."
*Confirmed delayed-release medications should not have been crushed and the physician should have been contacted for an alternative if the resident was unable to have taken the medication whole.
*She had not trained the new medication aides since they were already certified upon hire.
-"Since the medication aides are certified, they should know not to crush delayed-release medication."
*She was unsure who trained the CMAs to the facility medication pass.

Interview on 7/19/23 at 11:30 a.m. with nurse supervisor C and director of nursing (DON) B regarding the above observation, the medication aide training, competencies, and the crushing of delayed-release medications revealed:
*Both agreed delayed- release medications should not have been crushed.
*They would expect the CMAs to go to the licensed nurses with any medication questions.
*DON B reviewed resident 18's MAR and confirmed there were no instructions to not crush the resident's delayed-release medication.
*Confirmed the CMAs trained the new CMAs on the facility medication pass.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 19 *Nurse supervisor C stated they only complete a yearly medication pass competency with the CMAs. *Both confirmed new CMAs had no evaluation of their competency during the initial hire period. -They agreed most traveling CMAs would not have completed a year's employment during their assigned period at the facility and should have had a competency skills audit. *DON B stated the consulting pharmacist would perform random medication pass audits during her once a month visits to the facility. Phone interview on 7/19/23 at 2:32 p.m. and on 7/20/23 at 10:40 a.m. with consultant pharmacist R regarding resident 18's crushed medications, and the medication pass audits revealed: *She had been the facility's pharmacy consultant for little over a year. *Stated, "Delayed-release medications probably should not be crushed." *During her monthly visits, she would ask who ever was passing medications which residents were getting their medications crushed. *Every resident in the facility had a routine physician's order to 'crush medications as appropriate' upon admittance to the facility. -She felt that practice needed to change. *She was unaware the CMAs were crushing resident 18's medications, but thought it might have started when the resident's diet changed to pureed foods in May of 2023. -Crushing a divalproex (Depakote) DR medication would have been considered a medication error. *She visited the facility once a month to complete resident medication reviews and random medication pass audits with the CMAs. -She could not recall auditing CMA I and felt that	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 20	F 726		

was because CMA I had been recently hired since her last visit to the facility in June.
-Her audits of the CMAs were random, but she attempted to audit the newer CMAs.

Further interview on 7/20/23 at 12:10 p.m. with DON B regarding CMA I revealed:
*She agreed that no CMA competencies had been performed following the initial date of hire.
-Nurse supervisor C and infection prevention nurse (IP) E were responsible for the CMA competency audits and there had been no competencies completed in 2023.
-There was no nurse educator or staff development personnel at the facility.
-There was no nursing involvement in the training of the newly hired CMAs.

On 7/20/23 at 8:30 a.m. a request for all CMA medication administration training and competency audits for the past year were requested from DON B. By the end of survey, DON B stated the pharmacist's audits of newly hired CMAs had not been located.

A medication aide training policy was requested on 7/20/23 from DON B. She stated there was no policy.

Review of the provider's October 2022 Crushing Medications policy revealed:
*"Policy Statement"
-"Medications may be crushed for individuals with physical limitations secondary to disease processes and/or pathological diversities, when deemed necessary for safety, by the physician, speech therapy or nursing services."
-"3. The need for crushing medications is indicated on the resident's MAR/TAR so that all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 21 personnel administering medications are aware of this need." -"6. Long-acting or enteric-coated dosage forms should generally not be crushed and require a physician's specific order to do so." Review of the provider's February 2023 Adverse Consequences and Medication Errors policy revealed: *"Policy Statement" -"The interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems..." -"6. Examples of medications errors include: --h. Failure to follow manufacturer instructions and/or accepted professional standards (e.g., failure to shake medication that is labeled shake well, crushing a medication on the do not crush list without an order." 2. Record review and interview on 7/17/23 at 12:47 p.m. with CMA O preparing resident 32's Lactulose medication for administration revealed: *A physician's order read: "Lactulose 30 mg [milligram], four times daily. 2, 3, or 4 doses to = 120 mg." -Resident 32 was to have been administered two-30 mg Lactulose doses by CMA O during the day shift that day. Observation and interview at that same time in resident 32's room revealed: *CMA O had administered 30 mg of Lactulose. *The resident stated in addition to the two doses CMA O had administered to him during the day	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 22 shift he would have taken one additional "double dose [60 mg]" of the Lactulose during the evening shift. Interview on 7/18/23 at 3:30 p.m. with CMA K regarding resident 32's 7/17/23 evening medication pass revealed: *She had worked the 7/17/23 evening shift and had administered to the resident one-60 mg dose of Lactulose to the resident during her shift. *CMA O had reported to her at shift change on 7/17/23 that resident 32 had taken two-30 mg doses of Lactulose on his shift so she knew one additional 60 mg dose of Lactulose had equaled the daily 120 mg that was ordered. -Resident 32 had preferred to take his evening Lactulose in that manner. *She confirmed calculating the Lactulose dose was not within her scope of practice. Interview on 7/20/23 at 12:10 p.m. with DON B regarding the observation above revealed: *It had not been within CMA K's scope of practice to have calculated resident 32's Lactulose dose without first having consulted with a licensed nurse. *That Lactulose order should not have included a range of dosing frequencies. -That would have eliminated the need for a dose calculation. 3. Interview and review of resident 47's care record on 7/20/23 at 8:15 a.m. with CMA J revealed : *His physician order summary included an order: "May crush medications if indicated (unless contraindicated). May give in food or drink." -Each resident's physician order summary had that same routine order.	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 23 *The upper corner of the medication blister packs had instructions: "Do not crush. May cause drowsiness. May cause dizziness" for those medications that had been contra-indicated to crush. -Only his Flomax blister pack had those instructions on it. *All of his other medication blister packs including an extended-release Tylenol had not had those instructions. -She was aware an extended-release medication such as Tylenol should not have been crushed. *The resident's July 2023 MAR revealed there had been no instructions for any of those medications to have been crushed. *CMA J had administered all of resident 47's medications whole because she had determined he was not having any swallowing issues or other concerns that would have suggested the need to have crushed his medications. -She had used her "schooling [medication aide training]" to have made that decision. Interview on 7/20/23 at 12:10 p.m. with DON B regarding the observation above revealed: *It was not within CMA J's scope of practice to determine whether or not any resident should have had their medications crushed or not without first having a discussion with a licensed nurse. *Medication-crushing information on the resident's MAR and their individual blister packs had not been consistent and was confusing to interpret. 4. Interview on 7/20/23 at 8:30 a.m. with CMA J regarding CMA education revealed: *She had been a CMA at the nursing home for two years. -She had not received any medication	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 24	F 726		

administration education or demonstrated a medication administration competency within the past year.
*She and CMA L had been responsible for providing initial medication administration orientation for newly hired CMAs on the Berry unit.

Interview on 7/20/23 at 12:10 p.m. with DON B regarding CMA medication administration education revealed:
*Consulting pharmacist R had completed Med Pass Observation audits for random CMAs on a monthly basis.
*Only one of those audit tools had been located and it had been completed on 9/29/22 for CMA J.
*That audit tool included 23 individual medication administration-related tasks but only one of those 23 tasks had been audited.
-That task had been related to her medication cart and criteria for that task had been marked "Not Met."
-In-Service Notes at the bottom of that form: "Cart was found unlocked with med aid [CMA] in room, meds [medications] were preset and not covered, names were on cups. Communication on presetting medication reviewed with med aide. Will reassess actual med pass at the October [2022] review as cart was unlocked upon review."
*That audit tool had not comprehensively assessed CMA J's ability to competently administer medications to the residents.
*DON B had been unable to locate documentation to support any 2022 annual CMA medication administration education had been provided.
-No annual CMA medication administration education had occurred in 2023.
*Infection control (IC) nurse E was expected to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 25 have completed that education. -DON B thought she had sent IC E an e-mail communication in early 2023 regarding annual CMA medication administration education expectations but had not followed-up with her to ensure it had been started. *It was not within CMA J or L's scope of practice to have provided that education to newly hired CMAs on the Berry unit. -Initial medication administration orientation was expected to have been provided by a supervising nurse. The 6/15/23 Medication Aide job description had not identified any initial or ongoing education requirements for that position or medication administration tasks that should not have been delegated. -There was no other policy that had specifically addressed initial and ongoing CMA education and training requirements.	F 726		
F 849 SS=D	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	F 849	F849 Corrective Action: 1. For the identification of and lack of provider failing to ensure collaborative communication from hospice services was accessible to nursing home staff. This was corrected through collaboration with hospice services supervisor to ensure adherence to the current hospice policy titled Nursing Home record on 8/9/23. Resident 49's hospice binder updated with all current hospice information on 8/9/23. 2. Identification of Others: All current and future residents are potentially affected by the deficiency of failing to ensure collaborate communication from hospice services was accessible to nursing home staff. Education provided to all licensed nurses, CNA's, and IDT on Nursing Home record policy.	9/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 26 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 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	F 849	Per collaboration with the hospice supervisor, Nursing home record policy will be followed and that no edits need to be made. Per collaboration with hospice supervisor all hospice staff (nurses, aides, social workers, chaplains) have been educated on Documentation in Nursing Home Record policy. Per collaboration with hospice supervisor all hospice staff (nurses, aides, social worker, chaplains) have been educated on the process and use of the hospice binder. Additional education also provided that the progress notes section in hospice binder needs to be used every visit to show coordination of care between hospice and facility. Education provided to MDS coordinator that hospice paperwork must be filed timely. Education provided to all licensed nurses they do have access to look in hospice EMR to improve collaboration between hospice and facility. Education provided to all licensed nurses where to access hospice information within EPIC. DON or designee will ensure all facility staff responsible for the assigned task(s) have received education/training with documentation by 9/1/23 or before their next scheduled shift if unable to receive education prior to 9/1/23. The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies and procedures for the above identified areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 27 provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board 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.	F 849	Monitoring: Audit tool has been created to focus on ensuring hospice collaboration per nursing home record hospice policy. The Hospice Collaboration audit tool will continue for a minimum of 6 months. (i. e. two 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. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional educational opportunities will be directed by QAPI committee in response to audit reports. Audit tool has been created to audit collaboration between hospice services and facility. Audits will be performed by DON or designee; 3 to 5 audits will be performed weekly. After 4 weeks of monitoring demonstrating expectations are being met monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 28 §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written 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.	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 29 (D) Names and contact information for hospice personnel involved in hospice care of each patient. (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: Based on observation, interview, record review, and policy review, the provider failed to ensure collaborative communication was accessible to nursing home staff by one of one hospice agency for two of two sampled residents (4 and 49) who had been receiving hospice services. Findings include: 1. Observation and interview on 7/17/23 at 12:30 p.m. with an unnamed certified nurse aide (CNA)who had sat next to resident 49 in the Berry dining room revealed she: *Was from the agency that provided hospice services for the resident.	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 30	F 849		

*Had seen the resident once weekly to provide him "a little extra TLC [tender loving care]."
*Had spoken with the nursing home staff about how the resident had been doing during the previous week and shared any new observations she had made during her visits.
*Had documented her visits in the electronic medical record (EMR) system used by the hospice agency.
-Was unsure how or if nursing home staff had access to that information.

Review of the hospice agency's binder for resident 49 kept at the Berry nurses' station revealed it had included:
*The resident's medication list, unsigned comfort pack orders, and a hospice referral dated 3/28/23.
-There were tabbed dividers labeled hospice aide (CNA), social worker, chaplain, nurse, and volunteer.
-Behind those dividers were unused progress note forms for each of those disciplines.

Interview on 7/17/23 at 4:00 p.m. with licensed practical nurse (LPN) F and infection control (IC) nurse E regarding hospice services for resident 49 revealed:
*LPN F thought a hospice nurse and a hospice CNA visited the resident one to two times per week.
-She relied on reports from the previous shift or direct communication from the hospice nurse or CNA on those days when she worked and hospice isited to know things about the resident's hospice care.
*She was aware of the hospice binder referred to above but stated, "I don't use it."
*She confirmed there was no hospice related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 31	F 849		

information behind the "hospice" tab in the resident's nursing home chart either.
*IC nurse E stated the hospice agency used a different EMR system than the one the nursing home used.
-LPN F had not used that EMR system and was unsure if she even had access to it.

Interview on 7/19/23 at 1:30 p.m. with director of nursing (DON) B regarding hospice services revealed:
*There was no documentation in resident 49's medical record that supported collaboration occurred between the nursing home and the hospice agency regarding that resident.
*The hospice agency had used another EMR system for their hospice documentation but the nursing home nurses should have had access to that system.
*The Minimum Data Set (MDS) coordinator S was the liaison between the nursing home and the hospice agency.

Record review and interview on 7/19/23 at 2:35 p.m. with LPN Q on the Massa Unit revealed:
*Resident 4 had expired earlier that day and had been receiving hospice services.
*LPN Q thought the hospice binder usually contained only a hospice admission assessment.
*She had known that the hospice provider documentation was in a different EMR than the one in the nursing home and she had no access to the hospice EMR.
-"Only supervisors have access."

Interview on 7/19/23 at 4:40 p.m. with MDS coordinator S revealed:
*Hospice agency documentation was either sent to her by the hospice agency or provided directly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 32 to her from hospice staff during their hospice visits. -It was filed in the resident's hospice binder. *There were six sealed manila envelopes in her office that had contained individual hospice plans of care and hospice visit documentation dated between April 2023 and June 2023. -Those had not been filed due to "not currently having a ward clerk." *She agreed she could have filed that information. Follow-up interview on 7/19/23 at 5:00 p.m. with DON B regarding the interview with MDS coordinator S revealed she: *Had expected the hospice documentation referred to above should have been filed upon its receipt. *Was unaware that facility nurses had no access to the hospice agency's EMR. *Agreed collaboration and communication between the nursing home and hospice agency had not been evidenced based on the findings referred to above. Review of the September 2020 revised Documentation in Nursing Home Record policy revealed: "C. The hospice team, will document pertinent information after each visit with the resident. Copies of all visit notes will be placed on the nursing home chart or sent to the facility weekly."	F 849		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880	F880 Corrective Action: 1. For the identification of and lack of *Appropriate hand hygiene, and glove use for medication pass, water pass and personal care by licensed and unlicensed staff.	9/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880	Education provided to licensed and unlicensed staff regarding hand hygiene policy which includes glove use. Education provided to all licensed nurses and medication aides regarding medication/treatment administration general guidelines. Education provided to all licensed nurses and CNA's regarding peri care policy. Education provided to all licensed nurses and unlicensed staff regarding water pass. *Appropriate handling of scissors used during wound care. Education provided to all licensed nurses regarding dressing change policy. *Appropriate foley catheter care for drainage bags. Education provided to all licensed nurses and unlicensed staff regarding foley catheter care policy. Resident 49's catheter bag covered and removed from the floor 7/20/23. The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by Director of Nursing or designee by 9/1/23 or before their next scheduled shift if unable to receive education prior to 9/1/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure infection prevention and control practices were implemented for the following: *Proper hand hygiene and glove use during: -One of one random observations of a medication pass by one of one certified medication aide (CMA) (I) with two of two residents (9 and 19). -One of one water passes down Massa Hall by one of one certified nursing assistant (CNA) (T). -One of one resident's (42) personal hygiene performed by two of two CNA's (T and U). *Handling of scissors used during one of one sampled residents (49) wound care by one of one infection control (IC) nurse (E) and one of one	F 880	2. Identification of Others: All residents and staff have the potential to be affected by lack of: *Appropriate resident care needs as noted in above identified care areas. Policy education/reeducation about roles and responsibilities for the above identified assigned care and services tasks will be provided by Director of Nursing or designee by 9/1/23 or before their next scheduled shift if unable to receive education prior to 9/1/23. System Changes 1. Root cause analysis conducted answered the 5 whys: *For the identification of lack of Appropriate hand hygiene, and glove use for medication pass, water pass and personal care: Caregivers are not competent on hire about hand hygiene, and glove use for medication pass, water pass and personal care. Intervention: Education provided to licensed and unlicensed staff regarding hand hygiene policy which includes glove use. Education provided to all licensed nurses and medication aides regarding medication/treatment administration general guidelines. Education provided to all licensed nurses and CNA's regarding peri care policy. Education provided to all licensed nurses and unlicensed staff regarding water pass. Corrective action not being given for not following hand hygiene in areas stated above. Intervention: Caregivers will be corrected in real time, if continues corrective action will be implemented. Caregivers are reluctant to sanitize hands due to their hands getting dried out. Intervention: Education provided for all licensed and unlicensed staff that lotion is supplied for staff to use if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35 licensed practical nurse (LPN) (F). *Ensuring one of two sampled residents (49) who had a Foley catheter had his uncovered urine collection bag kept off the floor in his room while he was in bed. Findings include: 1. Random observation on 07/17/23 at 1:10 p.m. of CMA I administering medications to residents in the Massa dining room revealed: *After taking a sip of a soft drink and without sanitizing her hands CMA I: -Removed resident 19's medications from the medication cart, crushed them, mixed them in pudding, and spooned them into the residents mouth. -Touched the resident's clothing, then returned to the medication cart holding the empty medication cup and dirty spoon and disposed of it in the garbage container. *Then without sanitizing her hands she: -Documented the medication administration in the medication cart computer, opened the medication cart drawer, and removed a bottle of liquid medication. -Poured the liquid medication into a clean measuring cup, and administered the oral liquid medication to resident 9. -Returned to the medication cart holding the used medication cup and disposed of it in the garbage container. -Documented in the computer and stood at the medication cart without sanitizing her hands. Interview on 7/19/23 at 11:00 a.m. of CMA I regarding hand sanitization during the above observed medication pass revealed: *She had not liked to use hand sanitizer as it irritated her skin and she would wash her hands	F 880	Caregivers use gloves not according to the hand hygiene policy thinking it will protect them. Intervention: Education provided for all licensed and unlicensed staff regarding hand hygiene policy. *For the identification of lack of appropriate handling of scissors used during wound care: Caregivers are unaware of where to put scissors during wound care. Intervention: Education provided to licensed caregivers on the Dressing change policy. Corrective action is not being given if licensed nurses are not following wound dressing policy. Intervention: Caregivers will be corrected in real time. If continues corrective action will be implemented. *For the identification of lack of appropriate foley catheter care for drainage bags: Caregivers are unaware that foley catheter bags should be covered and off the floor. Intervention: Education provided to all licensed and unlicensed caregivers on Foley Catheter Care policy. Caregivers are unaware where foley catheter bag covers are stored in the facility. Intervention: Education provided to all licensed and unlicensed caregivers regarding the location of where foley catheter bags are stored.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 36 with soap and water if they became dirty. *She was not aware she should wash her hands before and after each resident's medication administration, especially if she had touched the resident or the supplies that had come in contact with the resident's mouth. 2. Observation on 07/17/23 from 3:16 p.m. through 3:22 p.m. of CNA T during the resident water pass down Massa unit from rooms 62 through 69 revealed: *She had one water pass cart that carried clean, filled, water containers on the top shelf and used, emptied, water containers on the bottom shelf that were placed into a un-enclosed plastic crate. *Without sanitizing her hands she: -Entered each room and emptied the used water containers into the resident's sink then removed the water containers and placed them on the lower shelf of the cart located in the hallway. -Picked up the clean, filled water containers and took them into the room. -She went from room to room in that same manner. *She had not sanitized or washed her hands during the entire observed resident water pass down the hallway. Interview on 07/17/23 at 3:45 p.m. with CNA T regarding the above observation revealed: *She had worked as a CNA at this facility for approximately two weeks. *She had on-line hand hygiene training and had performed a hand hygiene audit at the facility. *That was how she would normally pass resident water down the hallway. *She should have washed or sanitized her hands before entering and after leaving each room. *Agreed there were multiple missed opportunities	F 880	Not enough catheter bag covers are available in the facility to ensure foley catheter care policy is being followed. Intervention: Additional catheter bag covers purchased. 2. Administrator, DON, Medical director, and any others identified as necessary will ensure all facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation by 9/1/23 or before their next scheduled shift if unable to receive education prior to 9/1/23. Administer and Director of Nursing contacted the South Dakota Quality Improvement Organization on 8/9/23. Based on our conversation with the QIO this facility has a good understanding of the quality improvement methodology. Facility provided Root cause analysis to the QIO and reviewed without additional recommendations suggested. QIO suggested a "code word" for caregivers to use if they notice a breach/gap in standard infection control and prevention practices. QIO also suggested a "secret shopper" approach when auditing these areas. QIO also ensured the facility had a tool to use for auditing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37 for hand sanitization during the water pass. 3. Observation on 07/17/23 at 3:26 p.m. of CNAs T and U during a Hoyer transfer and an incontinent brief change on resident 42 in her room revealed: *Both CNAs entered the room and applied gloves without sanitizing their hands. -CNA U applied two pairs of gloves to her hands. *After applying the Hoyer sling on resident 42, the battery to the Hoyer was not working so CNA T removed her gloves and without sanitizing her hands left the room with the dead battery. -She retrieved a new battery from a storage room. -On her way back to the room, she stopped to open a snack for an unidentified resident sitting in the hallway. -She re-entered the room and applied gloves without sanitizing her hands. *Once the resident was placed on the bed, both CNA's removed the resident's brief and cleansed a bowel movement off resident 42's bottom. -CNA U removed the first layer of gloves, and without sanitizing her hands and wearing the underlying pair of gloves, she placed a clean brief under the resident. *Using the same pair of soiled gloves, CNA T opened the resident's bedside table drawer, removed a skin barrier cream tube, applied the cream to the resident's cleansed buttocks, then returned the tube of barrier cream to the drawer. -She removed her gloves and without sanitizing her hands applied a clean pair of gloves to remove the Hoyer sling, adjust the resident in bed, and move the Hoyer into the hallway. *Both CNAs then removed their gloves and sanitized their hands upon leaving the room.	F 880	3. Monitoring DON and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified areas. *Any other areas identified through the Root Cause Analysis. 4. Separate audit tools have been created to focus on all separate areas. *Appropriate hand hygiene, and glove use for medication pass, water pass and personal care.*Appropriate handling of scissors used during wound care.*Appropriate foley catheter care for drainage bags. Audit tools will continue for a minimum of 6 months. (i.e two 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. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional educational opportunities will be directed by the QAPI committee in response to audit reports. Audit tool has been created to audit that facility policies are being followed. Audits will be performed by DON or designee; 3 to 5 audits will be performed weekly. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 Interview on 07/17/23 3:45 p.m. with CNAs T and U regarding the above observation revealed: *CNA T had started working at the facility approximately two weeks ago and had over ten years of CNA experience. *CNA U had started working at the facility approximately one week ago. *They both had completed the facility's hand washing and glove use training through an online course and performed a hand hygiene competency with nurse supervisor D. *They both stated hand hygiene should have been performed when entering and upon exiting a resident's room. -Neither one identified hand hygiene and changing gloves when moving from a dirty task to a clean task or after removing soiled gloves. -CNA U had not been aware that she should not have applied two pairs of gloves at the same time. *Both agreed there had been missed opportunities for proper hand hygiene and glove use. Interview on 07/20/23 at 01:27 p.m. with infection prevention (IP) nurse E regarding the above observations revealed: *Hand sanitizing should have been performed after exiting every resident room during the water pass. -She had been unaware of the facility's water pass policy. *She had not completed any CNA audits of hand sanitization during a water pass. *If a CNA had not passed a hand hygiene audit, she would do "In Time" education. -Meaning she would educate them at the time of the observed occurrence. *She observed 43 hand hygiene audits last month	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39	F 880		

from all the various departments.
*There were no current performance improvement projects (PIP's) on hand hygiene and glove use.
*Her expectation for hand sanitization and glove use was it should have been performed when going from dirty to clean, after a glove change, and after leaving every room.
*She had just completed peri-care competencies in March of 2023 with all staff.
*New hire training on hand hygiene and glove use was online and with another CNA on the floor.
*Agreed there were missed opportunities for proper hand hygiene and glove use during the above observations.
-"They do a hand competency upon hire and should have known how to do it (properly)."

Review of the provider's February 2023 Water Pitcher and Drinking Glass policy revealed:
*All resident's water pitchers were to have been emptied and placed on a cart and taken to the dirty dish area in the dietary department.
*Staff were to wash their hands and then place the clean, filled, water pitchers on a clean cart to pass to the resident's rooms.

Review of the provider's December 2022 Hand Hygiene policy revealed:
*Hand hygiene should have been performed:
-Before having direct contact with residents.
-After contact with the resident's intact skin.
-When moving from a contaminated body site to a clean body site during resident care.
-Before preparing or handling medications.
-Before applying gloves and after removing gloves.
*Gloves should have been changed during resident care when moving from a soiled body

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40 site to a clean body site. 4. a. Observation on 7/18/23 at 3:00 p.m. of IC nurse E and LPN F in resident 49's room revealed: *He was lying on his back in bed. *His uncovered urine collection bag hung at the foot of his bed and was touching the floor. -The bag no longer touched the floor after his bed was raised to a higher position for his wound care treatment. *IC nurse E removed a pair of scissors from the back pocket of LPN F's scrubs, laid them directly on the resident's uncleaned bedside table with other pre-packaged wound care supplies. *Without cleaning those scissors IC nurse E removed a foam wound dressing from its package and used those same scissors to cut that dressing that was applied to the resident's left heel. -She laid the scissors back down on the uncleaned bedside table and completed the dressing change. *The resident's bed was then returned to a low position causing his urine collection bag to touch the floor. Interview on 7/18/23 at 4:00 p.m. with IC nurse E and LPN F regarding the wound care observation referred to above revealed the following practices had presented an unnecessary infection control risk to resident 49: *Transporting wound care scissors inside a clothing pocket. *Failing to ensure those scissors had been cleaned prior to use. Review of the revised June 2019 Dressing	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41 Change policy revealed: "A. 9. Establish a clean area for dressing supplies and necessary equipment." b. Observation and interview on 7/18/23 at 5:00 p.m. with LPN F outside of resident 49's room revealed: *He was lying in bed and his uncovered urine collection bag hung at the foot of his bed touching the floor. *LPN F stated she had not noticed the bag touching the floor at the time of his wound care earlier that day. *She knew the uncovered bag touching the floor presented an unnecessary infection control risk to the resident. Observation and interview on 7/19/23 at 10:45 a.m. with IC nurse E and LPN F outside of resident 49's room revealed: *He was lying in bed and his uncovered urine collection bag hung at the foot of his bed and was touching the floor. -His urine collection bag should have been inside a secondary bag preventing that uncovered bag from directly touching the floor. Review of the February 2019 revised Foley Catheter Care policy revealed: "G. When the resident is in bed or seated, assure collection bag is off the floor and covered for dignity and hygiene." Refer to F550.	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 7/17/23 through 7/20/23. Monument Health Sturgis Care Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi Ellwein | TITLE: President | (X6) DATE: 8/3/2023

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING **01 - MASSA** B. WING _____	**07/18/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/18/23. Monument Health Sturgis Care Center building 1 (Massa) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Schmidt — TITLE: President — (X6) DATE: 8/3/2023

RECEIVED
AUG 10 2023
DOH-OLC

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING 02 - BERRY B. WING _____	07/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/18/23. Monument Health Sturgis Care Center building 2 (Berry) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Olmsted | TITLE: President | (X5) DATE: 8/3/2023

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

AUG 10 2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING 03 - ADMIN B. WING	07/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/18/23. Monument Health Sturgis Care Center Building 3 (Administration) 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 the deficiency identified at K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards..	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321	The three corridor doors in the Kitchen will be corrected with appropriate hold open hardware. July 18th, contractor was on site to assess doors in question. Hold opens to be installed no later than September 3, 2023. The Plant Operations Supervisor will monitor completion of work. Fire door locations with hold open devices tied into the fire alarm system will now be inspected and tested twice a year by onsite maintenance staff. Plant Operations Supervisor will report on the compliance of any improperly functioning fire doors from the testing and actions taken for correction to the Quality Assessment and Performance Improvement (QAPI) Program and Safety Committee.	9/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Elliott | TITLE: President | (X6) DATE: 8/3/2023

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING 03 - ADMIN B. WING	07/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 1 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain one hazardous area (kitchen supply storage) as required. Findings include: 1. Observation on 7/18/23 at 1:30 p.m. revealed the kitchen pantry was over 100 square feet in area and had copious amounts of combustibles (cardboard box goods) stored in it. The unrated door was not equipped with a closer and was kept in the open position to the kitchen. That would require the kitchen to be isolated from the adjacent egress corridor with self-closing doors. 2. Observation on 7/18/23 at 1:35 p.m. revealed the kitchen area immediately outside the pantry had copious amounts of canned goods stacked on racks approximately 15 feet in length and 5 feet in height. That condition would require the kitchen to be isolated from the adjacent egress corridor with self-closing doors. The east door from the serving line was equipped with a closer, but the door was binding in the frame and would not latch with the operation of the closer. 3. Interview with the maintenance plant operations director at the time of the above observations confirmed those findings.	K 321		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING **03 - ADMIN** B. WING _____	**07/18/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 2 The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment.	K 321		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10693	A. BUILDING: _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/17/23 through 7/20/23. Monument Health Sturgis Care Center was found not in compliance with the following requirement: S326.	S 000	S326 Corrective Action: 1. For the identification of and lack of provider failing to ensure there was licensed nursing oversight and supervision to ensure that CMA's in the facility had received initial and annual CMA competencies to ensure they are competent in medication pass was corrected by all current CMA's (including certified medication aides (CMAs) (J, K, L, N, P, I, M, and O) completing CMA medication pass competency. This was completed for all CMA's on 8/9/23. 2. Identification of Others: All current and future CMAs are potentially affected by the deficiency of provider failing to ensure there was licensed nursing oversite and supervision to ensure that CMA's in the facility are competent with medication pass. The facility will ensure future and current CMA's will complete initial and annual CMA competencies to ensure they are competent in medication pass. Facility job description for medication aide has been updated to include, Medication aide competencies will be completed on hire and on an annual basis. Medication aide competency will be tracked by DON or designee to ensure completion per medication aide job description. All identified education was provided to all specified staff as no later than 9/1/23, or before their next scheduled shift if unable to receive education prior to 9/1/23.	9/1/23
S 326	44:73:08:07 Medication Administration Medication administration shall comply with §§44:73:08:02 to 44:73:08:05, inclusive, and with the requirements for training in §§20:48:04.01:14 and 20:48:04.01:15 and for supervision in §20:48:04.01:02. The supervising nurse shall provide an orientation to the unlicensed assistive personnel who will administer medications. The orientation shall be specific to the facility and relevant to the residents receiving administered medications. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, personnel record review, and policy review, the provider failed to ensure: *Five of five certified medication aides (CMAs) (J, K, L, N, and P) had received annual medication administration education or had completed a medication administration competency. *Three of three CMAs (I, M, and O) had received initial medication administration orientation under the supervision of a licensed nurse. *There was a process in place to monitor the status of all CMA medication administration education and training. Findings include: 1. Interview 7/20/23 at 8:30 a.m. with CMA J on the Berry unit revealed: *She had been a CMA at the nursing home for	S 326		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: President — (X6) DATE: 8/10/2023

STATE FORM 6899 YYNJ11 — If continuation sheet 1 of 3

RECEIVED
AUG 15 2023
SD DOH-OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10693	A. BUILDING: _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 326	Continued From page 1 two years. -She had not received any medication administration education or demonstrated medication administration competency within the past year. *She and CMA L were responsible for providing initial medication administration orientation for newly hired CMAs on that unit. Review of personnel records revealed the following: *CMA J (4/21/21), CMA K (3/16/20), CMA L (3/25/19), CMA N (3/14/22), and CMA P (1/10/22) had hire dates that were over one year. *CMA I (6/12/23), CMA M (1/9/23), and CMA O (3/20/23) had hire dates that were less than one year. Interview on 7/20/23 at 12:10 p.m. with director of nursing B regarding CMA medication administration orientation and ongoing education and competency demonstration revealed she: *Confirmed newly hired CMAs had not been provided an orientation specific to the facility and relevant to the residents receiving medications. -Had known the orientation and education should have occurred by a supervising nurse and not a CMA. *Had known annual medication administration education or competency demonstration was expected to have been completed by all other CMAs. *There was no system to track when CMAs had received medication administration education and training to ensure timely completion. Review of the 6/15/23 Medication Aide job description revealed there was no expectation for initial orientation or annual training in all aspects of CMA medication administration.	S 326	The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies and procedures for the above identified areas. Monitoring: Audit tool has been created to focus on ensuring CMA's within the facility are competent when passing medications. The CMA medication pass audit tool will continue for a minimum of 6 months. (i. e. two 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. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additional educational opportunities will be directed by QAPI committee in response to audit reports. Audit tool has been created to audit that CMAs are competent with medication administration. Audits will be performed by DON or designee; 3 to 5 audits will be performed weekly. After 4 weeks of monitoring demonstrating expectations are being met monitoring may reduce to twice monthly. Monthly monitoring will continue at a minimum for 6 months.	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10693	A. BUILDING: _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/17/23 through 7/20/23. Monument Health Sturgis Care Center was found not in compliance with the following requirement: S326.	S 000	S326 Corrective Action: 1. For the identification of and lack of provider failing to ensure there was licensed nursing oversight and supervision to ensure that CMA's in the facility had received initial and annual CMA competencies to ensure they are competent in medication pass was corrected by all current CMA's (including certified medication aides (CMAs) (J, K, L, N, P, I, M, and O) completing CMA medication pass competency. This was completed for all CMA's on 8/9/23. 2. Identification of Others: All current and future CMAs are potentially affected by the deficiency of provider failing to ensure there was licensed nursing oversite and supervision to ensure that CMA's in the facility are competent with medication pass. The facility will ensure future and current CMA's will complete initial and annual CMA competencies to ensure they are competent in medication pass. Facility job description for medication aide has been updated to include, Medication aide competencies will be completed on hire and on an annual basis. Medication aide competency will be tracked by DON or designee to ensure completion per medication aide job description. DON or designee will ensure all facility staff responsible for the assigned task(s) have received education/training with documentation by 9/1/23 or before their next scheduled shift if unable to receive education prior to 9/1/23.	
S 326	44:73:08:07 Medication Administration Medication administration shall comply with §§44:73:08:02 to 44:73:08:05, inclusive, and with the requirements for training in §§20:48:04.01:14 and 20:48:04.01:15 and for supervision in §20:48:04.01:02. The supervising nurse shall provide an orientation to the unlicensed assistive personnel who will administer medications. The orientation shall be specific to the facility and relevant to the residents receiving administered medications. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, personnel record review, and policy review, the provider failed to ensure: *Five of five certified medication aides (CMAs) (J, K, L, N, and P) had received annual medication administration education or had completed a medication administration competency. *Three of three CMAs (I, M, and O) had received initial medication administration orientation under the supervision of a licensed nurse. *There was a process in place to monitor the status of all CMA medication administration education and training. Findings include: 1. Interview 7/20/23 at 8:30 a.m. with CMA J on the Berry unit revealed: *She had been a CMA at the nursing home for	S 326		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10693	A. BUILDING: _____ B. WING _____	07/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/17/23 through 7/20/23. Monument Health Sturgis Care Center was found in compliance.	S 000		