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 ______	06/09/2022

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 6/7/22 through 6/9/22. Monument Health Sturgis Care Center was found not in compliance with the following requirements: F677 and F880.	F 000	Corrective Action: 1.The deficiency for resident 28 was corrected by changing linens, providing a bath and nail care. Resident received a bath and nail care on 6/13/22 and 6/20/22. Resident 28 was admitted to hospital on 6/27/22 and has not returned to the facility at this time. 2.The deficiency for resident 34 was corrected by bathing resident, shaving, and cleaning glasses. Resident has had baths on 6/13/22 and 6/20/22. 3.The deficiency for resident 39 was correct by changing resident's shirt, cleaning residents' glasses, and bath. Weekly baths have been offered to resident since at least from the date of July 1st. Resident did refuse one bath in the past month. 2. Identification of Others: All current and future residents are potentially affected by the deficiency regarding ADL Care Provided for Dependent Residents findings related to resident, 28, 24, and 39. Bath policy reviewed with all CNAs, Licensed Nursing Staff, and housekeeping staff. Re-education provided to both scheduled bath aides regarding bath policy and roles and responsibilities on 6/28/22. Bath schedule hours and days of the week were adjusted to assist with all residents receiving a bath per facility policy.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The provider failed to ensure 5 of 15 sampled residents (9, 28, 34, 37, and 39) reviewed for personal hygiene had received a shower or bath in accordance with their plan of care. Findings include: 1. Observation and interview on 6/7/22 at 10:04 a.m. with resident 28 revealed: *He was in bed. *The pillowcase he was using had numerous brown spots on it. *His fingernails were over 1/4 inch long and had a brown substance underneath them. *He had not had a bath in the last 30 days. Interview and observation on 6/8/22 at 4:48 p.m. with resident 28 regarding bathing revealed: *He kept track on his cell phone of the days he had received baths. *Since February 2022 he had received a bath on: 2/22/22, 3/7/22, 3/24/22, and 4/15/22. -He had not kept track of his baths in May 2022,	F 677		7/5/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark C. Schmidt	President	7/1/2022

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

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F 677	Continued From page 1 but thought he had received one or two. *Everyone was supposed to get two baths per week but he had never known anyone to have received that. *The reason for not receiving a bath each week was because the provider was short staffed, and the bath aides were re-assigned to work on the floor. -There were two full-time bath aides. *Another issue was coordinating the bath aide and housekeeping, as housekeeping was to change bedding when residents had bath, and if the housekeeper was busy the bedding wasn't changed until the next bath. Review of resident 28's bathing records revealed from 5/2/22 through 6/9/22 he had received a bath on 5/16/22 and 5/30/22. 2. Observation and interview on 6/7/22 at 11:20 a.m. with resident 34 revealed he: *Was in his wheelchair in the dining room. *Had unkept hair, was unshaved, and had dirty glasses on. *Received baths once a week or every other week. Review of resident 34's bathing records revealed from 5/3/22 through 6/9/22 he had received a bath on 5/5/22, 5/13/22, and 5/26/22. 3. Observation and interview on 6/7/22 at 3:23 p.m. with resident 39 revealed she: *Was in bed and wore a shirt that had stains and cookie crumbs on it. *Had dirty glasses on and her hair was unkept and dirty. *Received a bath once a week or every other week.	F 677	Bathing schedule changes discussed at resident council. No concerns were expressed. Education for all CNAs, Licensed Nursing staff, and EVS staff regarding bathing policy and new bathing schedule. All identified education was provided to all specified staff as no later than 7/5/22, or before their next scheduled shift if unable to receive education prior to 7/5/22. System Changes: 3. Root cause analysis conducted answered the 5 whys: *For the identification of lack of ADL Care provided for Dependent residents. Bath aides being pulled to the floor and unable to assist with bathing. Intervention, education for all Licensed nurses and CNAs that bath aides will no longer be pulled to the floor. Bath aides not working scheduled shifts. Intervention: Corrective action will be given as needed and replacement for bath aide duty will be designated to another caregiver.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 677 Continued From page 2

Review of resident 39's bathing records revealed from 5/3/22 through 6/9/22 she had received a bath on 5/25/22, 6/1/22, and 6/8/22.

4. Review of resident 9's bathing records revealed from 5/5/22 through 6/9/22 she had received a bath on 5/9/22, 5/12,22, and 5/27/22.

5. Review of resident 37's bathing records revealed from 5/3/22 through 6/9/22 she had received a bath on 5/3/22 and 5/17/22.

Interview on 6/9/22 at 9:36 a.m. with director of nursing B regarding bathing revealed:
*There were two bath aides.
*Residents were to get one bath per week or when they requested one.
*Documentation of bathing should have been in each residents' electronic medical record.
-Sometimes staff would only document bathing in the "bath books."
*At times, the night shift would assist residents with their baths and did not always document that.
*She had never received any grievances regarding bathing.
*Baths for each resident were scheduled when they were admitted.
-The admitting nurse was to ask the resident what their preferences were.
-The day and time of that was determined by how what time and day was available according to the bathing schedule.
--Baths were only scheduled between 6 a.m. and 2:30 p.m.
--If the resident preferred an evening bath, they would try to accommodate that.
*If "not applicable" was checked on charting she

F 677

Residents refuse baths and documentation does not reflect this. Intervention, documentation in medical record will be adjusted to have only the designated bath aides document regular scheduled baths.

Documentation does not reflect accurate picture of baths being given. Documentation will be completed in medical record only, not on paper as well.

Process unestablished to ensure baths are given if bath aide is not present, resident refuses because of time offered, or resident is unavailable. New process implemented to assist with giving baths per our facility bath policy. Hours and days of the week have been adjusted. Bathing schedule changes discussed at resident council.

Administrator and Director of Nursing contacted the South Dakota Quality Improvement Organization on 6/28/22. Based on our conversation the QIN verbalized that we have a good understanding of quality improvement methodology. Root cause analysis was reviewed and a tour of QPIN's website was given via screen sharing along with a quick tutorial on the

Performance Auditing Tracking Tool. QIN suggested a "secret shopper" approach in the auditing activities and or having peers use a "code word" to each other if they notice a gap/breach in standard infection control and prevention practices.

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F 677	Continued From page 3 did not know what it meant. *She did not know if residents were offered a bed bath if they refused their bath or shower. Review of provider's undated admission agreement form revealed "The Long Term Care Facility: *Agrees to furnish room, meals, ...nursing care, and routine hair care. We will provide ... and such personal services as may be reasonably required for health, safety and well being of the resident." Review of provider's January 2018 Bathing policy revealed: *"Policy Statement: Residents are asked upon admission about bathing and bath preferences. Tub baths or showers are given at a minimum of once per week. Preferences and requests for more/less frequent bathing will be accommodated to the best of our ability. If resident requests or needs a bath more than once a week due to medical need two baths will be provided. *Guidelines: -A. If the bath aid (BA) is absent, every effort will be made to accommodate the residents bathing as scheduled for that day by the assigned CNA. It may be necessary to give a resident their bath at a different time than what has been established on the bathing schedule. In this case, an alternate day and time will be set up with the resident for them to receive their bath, for example, the next day. -B. Resident bathing will be documented in the electronic medical record. -C. Nails are to be checked with each bath for cleanliness, trimmed as needed, and documented."	F 677	Monitoring: 4. Audit tool has been created to focus on residents are receiving a bath per facility policy. The Bathing 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 baths are being given 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.	
F 880 SS=E	Infection Prevention & Control	F 880		7/5/2022

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F 880	Continued From page 4 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 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	F 880	Corrective Action: 1.For the identification of lack of *Appropriate hand hygiene, glove use, and procedural technique wound care and personal care by licensed and unlicensed staff. Education provided to licensed and unlicensed staff regarding Hand Hygiene policy which includes glove use. Education provided to all licensed nurses and CNAs regarding peri care policy. Education provided to all licensed nurses regarding dressing change policy. *Appropriate cleaning of mechanical lift slings and lifts between residents. Education provided to all licensed and unlicensed staff regarding equipment cleaning policy to include mechanical lifts slings and lifts between residents. *Appropriate transport and disposal of soiled linens. Education provided to all licensed nurses, CNAs, and EVS staff regarding transportation of soiled linen policy *Appropriate maintenance of oxygen cannula tubing when not in use by the resident. Education provided to licensed and unlicensed staff regarding changing oxygen humidifier bottles and tubing/cleaning 02 concentrator filters policy.	7/5/2022

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F 880	Continued From page 5 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 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 maintained for: *Proper glove use, hand hygiene, and disposal of soiled dressing supplies by one of one registered nurse (RN) (G) during one of one observed wound care procedure. *Proper glove use during personal care and between a care transition by one of one certified	F 880	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 7/5/2022 or before their next scheduled shift if unable to receive education prior to 7/5/22. 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/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by Director of Nursing or designee by 7/5/2022 or before their next scheduled shift if unable to receive education prior to 7/5/22.	

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F 880 Continued From page 6
nurse aide (CNA) (I) for one of one sampled resident (12).
*Cleaning of a shared mechanical lift sling used by one of one sampled resident (32).
*Cleaning of one of two mechanical lifts following two of two observed mechanical lift transfers (12 and 32).
*Transportation of soiled resident linen by one of one CNA (J).
*Oxygen (O2) cannula care for two of two sampled residents (9 and 37) who required oxygen.
Findings include:

1. Observation and interview on 6/8/22 at 11:13 a.m. with RN G performing resident 32's wound care revealed she:
*Removed a dressing off the left lower extremity wound and placed the soiled dressing on the bedside table.
*Unfastened the resident's brief and touched the coccyx wound with the same soiled gloved hand.
*Pushed the resident call light to get assistance with the same soiled gloved hand.
*Removed her gloves and placed the soiled gloves on the bedside table.
*Applied clean gloves without performing hand hygiene.
-Throughout the wound care procedure RN G
-Throughout missed:
--Three opportunities for hand hygiene during glove changes.
--Two opportunities for glove changes and hand hygiene when moving from dirty to clean.
*Agreed soiled, used gloves and soiled dressings should have been placed in a garbage can and not on the bedside table.
*Missed several opportunities for hand hygiene and glove changes during the wound care.

F 880

System Changes:
1.Root cause analysis conducted answered the 5 Whys:

*For the identification of lack of Appropriate hand hygiene and glove use:

Caregivers not competent on hire about hand hygiene/glove use. Intervention: Perform hygiene/glove use competency on hire.

Corrective action not being give for not following hand hygiene/glove use policy. Intervention: Caregivers will be corrected in real time, if continues corrective action will be implemented.

Personal miniature bottles of hand sanitizer unavailable for staff. Intervention: Purchase personal sanitizers for all Licensed and unlicensed caregivers

Caregivers reluctant of sanitizing hands due to their hands getting dried out. Intervention: Purchase personal lotion for all Licensed and unlicensed caregivers

Caregivers use gloves not according to the hand hygiene policy thinking it will protect them. Intervention: Education for all licensed and unlicensed staff regarding hand hygiene policy.

*For the identification of lack of appropriate procedural technique wound care:

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F 880 Continued From page 7

*Had left her hand sanitizer on the medication cart in the hallway.

2. Observation and interview on 6/8/22 at 11:33 a.m. of CNA J assisting resident 32 with a mechanical lift transfer after the wound care above was completed revealed:
*She brought a sit to stand lift into the room with a sling hanging over it from the hallway.
-The lift and sling were used to transfer the resident into the wheelchair.
*The sling was removed from behind the resident and placed on the unmade bed.
*CNA J wiped off the lift with a Super Sani-Cloth disinfecting wipe and then picked up the sling off of the unmade bed and hung it over the cleaned lift.
*She had been employed one week and was orientated to use the cloth slings between multiple residents.
*The cloth sling was a non-cleanable surface and that using the same sling between residents had the potential to spread infections.

3. Observation and interview on 6/9/22 at 9:40 a.m. with CNA/bath aide K regarding the use of lifts and cloth slings revealed:
*A lift was in the whirlpool room with a cloth sling hanging on the lift.
*CNA/bath aide K reported the lifts were cleaned between each resident with Super Sani-Cloth disinfectant wipes.
*She believed the slings were washed daily and were used for multiple residents.
*Super Sani-Cloth disinfectant wipes were ineffective on cloth surfaces like slings.
*Using the same sling for multiple residents was a common facility practice.

F 880 (Plan of Correction)

Wound dressing competency is not completed on annual basis. Intervention: Wound dressing competency will be scheduled to be completed annually.

Licensed Nurses to do not have the supplies to ensure dressing is being changed per policy. Intervention: DON or designee will ensure supplies are available and education provided to licensed nurses on where to find supplies.

Corrective action 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.

Audit process not implemented to ensure dressings are being changed per wound dressing policy. Intervention: Audits will be completed as stated below.

Licensed nurses not using additional staff to help with dressing change when needed. Intervention: Education to Licensed nurses to ask for additional assistance if needed prior to starting wound dressing.

*For the identification of lack of appropriate personal cares:

Personal care education not being completed on an annual basis and as needed. Intervention: DON or designee will ensure peri care education is completed annually and as needed.

Supplies to perform personal cares are not being stocked at bedside. Intervention: Education provided to ensure supplies are being stocked.

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F 880	Continued From page 8 Interview with infection control nurse C and director of nursing (DON) B on 6/9/22 at 2:25 p.m. regarding infection control revealed: *The facility trained staff on infection prevention during new employee orientation and annual training. *The infection control nurse completed monthly and random hand hygiene and infection control audits and monitoring with in time correction training with staff as needed. *Staff had completed hand washing competencies at new hire orientation and annual training. *The nurses received more specific training and competencies for wound care at new hire orientation and annually. *The expectations of infection prevention for a nurse performing wound care were to designate a clean field and to change gloves and perform hygiene when required. *The expectation for the use of lifts and slings used in between multiple residents were the lifts were cleaned between each resident. *The DON was working on getting each resident their own slings and had ordered additional slings. *Administration was aware that each resident should have had their own slings. *Infection prevention was not maintained during wound care for resident 32 by RN G by not maintaining hand hygiene and not disposing of soiled gloves and a soiled dressing properly. *A cloth sling was not a cleanable surface. 4. Observation on 6/7/22 at 11:15 a.m. of CNA I performing personal care with resident 12 revealed:	F 880	Personal miniature bottles of hand sanitizer unavailable for staff. Intervention: Purchase personal sanitizers for all Licensed and unlicensed caregivers Audit process not implemented to ensure personal cares are being completed per policy. Intervention: Audits will be completed as stated below. Lack of positive reinforcement for completing personal care tasks correctly. Intervention: Positive reinforcement for completing personal care correctly will be completed during audits. *For the identification of lack of appropriate cleaning of lifts: Germicidal disposable wipes aren't consistently stocked in lifts and hallways. Intervention: Education for all Licensed and unlicensed staff to stock germicidal disposable wipes. Licensed and unlicensed staff not educated to ensure lifts are cleaned between residents. Intervention: Education for all Licensed and unlicensed staff to clean lifts per Equipment Cleaning policy. Gloves not available in lifts to apply prior to using germicidal disposable wipes. Intervention: Education for all Licensed and unlicensed staff to stock gloves.	

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F 880	Continued From page 9 *With gloved hands she removed his soiled brief and performed peri-care. *She placed her unclean gloved hands directly on top of a clean brief, slid that brief underneath the resident, and fastened the brief. *Without changing her unclean gloves she immediately transferred him from his bed to his wheelchair using a mechanical lift. *She removed her gloves, performed hand hygiene, and put on clean gloves. *She moved the lift to the hallway outside of his room without disinfecting it. Interview on 6/7/22 at 1:00 p.m. with CNA I regarding the observation above revealed: *She should have performed hand hygiene and applied clean gloves in between contact with unclean then clean areas. *The lift should have been disinfected after it had been used. 5. Observation and interview on 6/8/22 at 11:50 a.m. with CNA J entering the soiled utility room on the Berry unit revealed she: *Carried a bundle of unclean resident bed linen in her arms held against her upper body. *Had not known soiled linen should have been contained prior to leaving a resident's room to prevent potential cross-contamination during its transport. Interview on 6/8/22 at 3:00 p.m. and on 6/9/22 at 2:25 p.m. with infection control nurse C revealed: *Staff had been trained on infection prevention and control during new employee orientation and annually. -Ongoing competency testing, additional education, and audits related to infection prevention and control occurred for all staff.	F 880	Corrective action not being given if Licensed nurses and unlicensed staff are not following equipment cleaning policy. Intervention: Caregivers will be corrected in real time, if continues corrective action will be implemented. Lack of positive reinforcement for completing cleaning lifts correctly. Intervention: Positive reinforcement for completing lift cleaning correctly will be completed during audits. *For the identification of lack of appropriate cleaning of lifts slings: Policy not established for sling use. Intervention: Equipment Cleaning policy revised. Not enough slings available in facility to ensure revised equipment cleaning policy is being followed. Intervention: More lift slings purchased Licensed and unlicensed staff not educated to not share slings between residents. Intervention: Education for all Licensed and unlicensed staff to clean and use slings per Equipment Cleaning policy.	

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 ______	06/09/2022

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 10

*A clean field should have been designated on which to lay clean wound supplies.
*Gloves should have been changed and hand hygiene performed any time staff moved between unclean then clean areas while caring for their residents.
*Gloves should have been changed and hand hygiene performed between all transitions in resident care.
*Each resident should have had their own sling for use with the designated mechanical lift they used.
*Shared resident equipment was disinfected between resident use, and unclean resident laundry was bagged inside a resident's room prior to removing it from that room.

Review of the January 2022 Hand Hygiene policy revealed:
*"POLICY STATEMENT
-It is the policy of Monument Health for all caregivers and providers to practice proper and appropriate hand hygiene. Decontamination of hands is accomplished using a combination of proper handwashing and use of alcohol-based hand rub (ABHR). Monument Health shall ensure that employees perform hand hygiene when indicated as recommended by the World Health Organization ("My 5 moments for Hand Hygiene").
*GUIDELINES
-A. Indications for handwashing and alcohol-based hand rub use"
--"8. Clean hands if moving from a contaminated body site to a clean-body site during patient/resident care."
--"11. Clean hands before donning gloves.
--12. Clean hands after removing gloves."

F 880

Individual slings not accessible in residents' rooms. Interventions: Hooks purchased to hang slings in resident's rooms until hooks are obtained resident slings will be hung on hangers.

Slings not returning from laundry. Intervention: New bins established for dirty slings on both units

*For the identification of lack of appropriate transport and disposal of soiled linens.

Licensed and unlicensed staff not educated on appropriate transport and disposal of soiled linens. Intervention: Education for all Licensed and unlicensed staff and EVS on how to transport and dispose of soiled linens per Transportation of soiled Linen policy.

Plastic bags to hold soiled linens are not easily accessible. Intervention: Education for all Licensed and unlicensed staff on stoking plastic bags to hold soiled linens.

Corrective action not being given if Licensed nurses and unlicensed staff are not following transportation of soiled linen 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 ____	06/09/2022

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 11 Review of the revised January 2022 Equipment Cleaning policy revealed: *"A. All equipment must be wiped down with a Sani-Cloth or other equivalent germicidal disposable wipe in between resident use." *"C. An example of equipment that requires cleaning in between resident use include but is not limited to: pulse oximeter, blood pressure machines, lifts, and suction machines." Review of the March 2021 Standard Precautions policy revealed: *1. Gloves: -"b. Gloves will be changed between each patient and when going from contaminated to clean sites with the same patient." *V. Laundry: -1. "All soiled linen will be bagged at the location where it was used." 6. Observation on 6/7/22 at 11:56 a.m. of resident 37 revealed: *She was in the dining room in her wheelchair. *There was a portable O2 tank attached to the back of her wheelchair. *The O2 cannula was off of her face and laid against the spokes of the wheel on the left side of her wheelchair. Observation on 6/9/22 at 1:05 p.m. of resident 37's room revealed: *She was in her room, and her O2 was administered through a portable tank. *There was a concentrator in her room with O2 tubing and a cannula attached to it. -The tubing and cannula laid on the floor. Review of resident 37's medical record revealed: *Her 4/5/22 Brief Interview for Mental Status (BIMS) revealed a score of 4, meaning her	F 880	Intervention: Caregivers will be corrected in real time, if continues corrective action will be implemented. Lack of positive reinforcement for completing transportation of soiled linens correctly. Intervention: Positive reinforcement for completing transportation of soiled linens correctly will be completed during audits. Licensed staff, unlicensed staff, and EVS employees are not receiving education regarding transportation of soiled linens policy on a regular basis. Intervention: Education for all Licensed and unlicensed staff and EVS on how to transport and dispose of soiled linens per Transportation of soiled Linen policy will be implemented annually and as needed. *For the identification of lack of appropriate maintenance of oxygen cannula tubing when not in use by the resident. Container not available to put nasal cannula in when not in use. Intervention: Respiratory bags purchased and placed on oxygen concentrators. Licensed and unlicensed staff not education regarding where to put the nasal cannula when not in use. Intervention: Changing oxygen humidifier bottles and tubing/cleaning O2 concentration filters policy reviewed. Oxygen tubing is longer than needed. Intervention: Licensed and unlicensed staff will receive education to not use extended tubing unless necessary.	

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 ______	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880 Continued From page 12
cognition was severely impaired.
*Diagnoses of heart disease, vascular dementia, seizures, Alzheimer's Disease, chronic obstructive pulmonary disease (COPD), and dependence on supplemental oxygen.
*A 6/17/20 physician order for O2 at 2 liters per minutes (LPM) continuously.
*Her care plan included she was at risk for breathing difficulties due to her diagnosis of COPD.
-She required the use of oxygen.

Observation on 6/7/22 at 11:29 p.m. of resident 9's room revealed she was not in her room and her O2 tubing and cannula laid on the arm of her recliner.

Observation on 6/8/22 at 10:30 a.m. of resident 9's room revealed she was not in her room and her O2 tubing and cannula laid on a quilt on her bed.

Review of resident 9's medical record revealed:
*Her 5/4/22 BIMS score was a 2, meaning her cognition was severely impaired.
*A 10/28/21 physician order for O2 at 2 LPM by nasal cannula.
*Her care plan: included a diagnosis of anoxic brain damage.

Interview on 6/9/22 at 1:21 p.m. with CNA L regarding O2 use by residents revealed:
*Cannulas not in use were rolled up and put on the resident's overbed table.
-They were not using a plastic bag to store the cannulas.
*If a cannula was not stored in a sanitary manner, it should have been wiped off with a disinfectant wipe.

F 880
Residents take off nasal cannula and do not put it in a clean dry location.
Intervention: Education for licensed and unlicensed staff if nasal cannula found in another place besides the clean bags, they are to the dispose and replace with new. Educate residents as well if appropriate on where to put nasal cannula when not in use.

Audit process not implemented to ensure nasal cannulas are being placed in a clean dry area per changing oxygen humidifier bottles and tubing/cleaning O2 concentrator filters policy. Audits will be completed as stated below.

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 7/5/2022 or before their next scheduled shift if unable to receive education prior to 7/5/22.

Administrator and Director of Nursing contacted the South Dakota Quality Improvement Organization on 6/28/22. Based on our conversation the QIN verbalized that we have a good understanding of quality improvement methodology. Root cause analysis was reviewed and a tour of QPIN's website was given via screen sharing along with a quick tutorial on the Performance Auditing Tracking Tool. QIN suggested a "secret shopper" approach in the auditing activities and or having peers use a "code word" to each other if they notice a gap/breach in standard infection control and prevention practices.

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 ______	06/09/2022

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 13 Interview on 6/9/22 at 2:00 p.m. with RN H regarding O2 use by residents revealed: *Each resident had their own O2 concentrator in their room and a portable tank for use when outside of their room. -The concentrator and the portable tank had their own tubing and cannula. *Cannulas were placed over the concentrator or over the handle of the concentrator when not in use. -The above procedure was not a good infection control practice. Interview on 6/9/22 at 2:15 p.m. with DON B revealed: *Each concentrator should have had a clean plastic bag attached to it for the tubing and cannulas storage when not used. -She was not aware the plastic bags were not in place. *She was not aware staff had been using a disinfectant wipe to clean cannulas. -This was not an acceptable infection control practice since the wetness of the disinfectant wipe could have created mold in the cannula. Review of the December 2021 Medication: Standard Schedule/Administration/Wasted/Placed on Hold policy revealed: *"POLICY STATEMENT: -Medications will be administered as ordered by the provider ..., in a therapeutic manner according to our standard schedule and documented appropriately in our electronic medical record..." *The policy did not address how the O2 equipment was to be maintained in a sanitary manner.	F 880	3. Monitoring: Administrator, 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 area. *Any other areas identified through the Root Cause Analysis. 4. Separate audit tools have been created to focus all separate areas,*Appropriate hand hygiene, glove use and procedural technique, wound care and personal cares by licensed and unlicensed staff, appropriate cleaning of mechanical lift slings and lifts between residents, appropriate transport and disposal of soiled lines, appropriate maintenance of oxygen cannula tubing when not in use by resident. 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 QAPI committee in response to audit reports.	

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 ______	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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			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	

PRINTED: 06/23/2022
FORM APPROVED
OMB NO. 0938-0391

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 ______	06/09/2022

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

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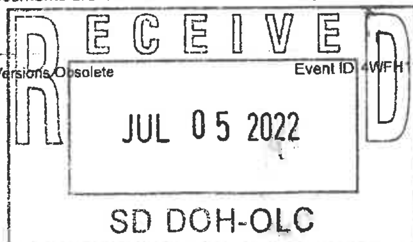
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 6/7/22 through 6/9/22. Monument Health Sturgis Care Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Schmidt | TITLE: President | (X6) DATE: 7/5/2022

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



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MASSA B. WING ______	(X3) DATE SURVEY COMPLETED 06/07/2022

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 6/7/22. 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 C Schmidt
TITLE: President
(X6) DATE: 7/5/2022

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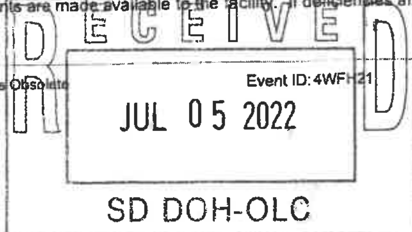

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING 02 - BERRY B. WING ______	06/07/2022

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

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/7/22. Monument Health Sturgis Care Center building 2 (Berry) 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 K211 and K911 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark C Schmidt
TITLE: President
(X6) DATE: 7/5/2022

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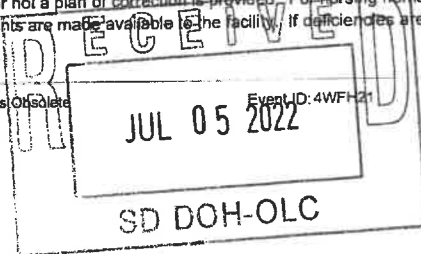

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435102	MULTIPLE CONSTRUCTION A. BUILDING: 02 - BERRY B. WING	DATE SURVEY COMPLETE: 6/7/2022
NAME OF PROVIDER OR SUPPLIER **MONUMENT HEALTH STURGIS CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **2140 JUNCTION AVENUE STURGIS, SD**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain an unobstructed path of egress for one of stair enclosure west of the nurse station for the Berry unit. The chairs were situated in a location directly in the path of egress in the stair enclosure from the marked EXIT adjacent to the nurse station. Other items were kept in the lower five locations (west stair enclosure for the Berry unit). Findings include: 1. Observation on 6/7/22 at 9:30 a.m. revealed two NuStep therapy chairs were kept in the lower level of the level landing area alongside the stairs but were not in the path of egress. Interview at the time of the observation with the plant operations manager confirmed that condition. He stated only staff members used that stair enclosure for access into and out of the building. This deficiency could affect 100 percent of the occupants of that smoke compartment.
K 911	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain control for one of one residential style electric stoves in the resident dining room of the Berry unit. Findings include: 1. Observation on 6/7/22 at 10:00 a.m. revealed a residential style electric stove in the resident dining room area of the Berry unit. The overhead vent had an open light socket (no lamp installed). The stove was also equipped with a lockable circuit box for the stove itself. The lock box was not locked. Upon opening the door of the box, the circuit was found to be shut off. After turning the switch to the on position, the stove's burners were tested and were discovered to have power at that point. Interview at the time of the observation with the plant operations manager confirmed that condition. He stated

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The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435102	MULTIPLE CONSTRUCTION A. BUILDING: **02 - BERRY** B. WING	DATE SURVEY COMPLETE: **6/7/2022**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 911	Continued From Page 1 the circuit box cover should have been locked. This deficiency affected one of numerous conditions required for the safety of the residents in that smoke compartment.

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

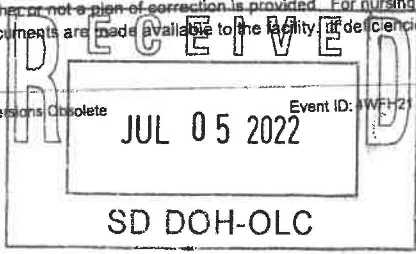
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING 03 - ADMIN B. WING ______	06/07/2022

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 6/7/22. Monument Health Sturgis Care Center Building 3 (Administration) 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: [signature]
TITLE: President
(X6) DATE: 7/5/2022

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.



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 ______	06/09/2022

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 6/7/22 through 6/9/22. Monument Health Sturgis Care Center was found not in compliance with the following requirement: S301.	S 000		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, the provider failed to ensure all required dietary trainings (food safety, handwashing, food handling/preparation, food-borne illness, serving and distribution, leftovers, time/temperature controls, nutrition/hydration, and sanitation) were completed by 16 of 16 dietary staff (M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, and BB). Findings include: 1. Interview on 6/8/22 at 3:45 p.m. with dietary manager E revealed he: *Had been dietary manager since Spetember 2021. *Was responsible for staff education and training. *Was unaware of required state dietary training expectations for new and existing staff.	S 301	For new hires all trainings and educations will be completed within the first week and documented accordingly. *Included :System annual safety, compliance, ethics, and security training. Dietary healthcare required training which includes: My great start orientation Annual bloodborne pathogens Annual dining associate workplace safety training Annual hazard communication *Core-Standards 24-5 training binder (The core standards are the training materials for managers to make sure we are covering what needs to be taught and have posters and resources needed for training. Trainings in this binder include: food safety, handwashing, food handling and preparation techniques, food borne illnesses, serving and distribution, procedures, leftover food handling policies, time and temperature controls for food prep and service, nutrition and hydration, and sanitation requirements.	7/22/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark C. Schmidt	President	7/1/2022

PRINTED: 06/23/2022
FORM APPROVED

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 301	Continued From page 1 Interview on 6/9/22 at 9:55 a.m. with food and nutrition system director CC revealed he was not aware of state regulations for dietary staff training. Interview on 6/9/22 at 1:00 p.m. with dietary manager E and food and nutrition system director CC revealed required dietary training had not been completed for any dietary staff since 2019.	S 301	For continued education and training for all staff we provide monthly CHAT meetings which go over a different section of the core standards in short 15-30 minute sessions. Going forward our training and education plan will be to continue to utilize the CHAT program monthly. We will hold annual training and competencies recertification covering all the materials listed above. We will do these recertification's beginning in March of each year, with all caregivers required to complete the trainings by the end of that month. This will correspond with the required annual trainings provided by health system. Timeline: We have already begun these trainings with our current staff and will have everyone completed by 7/22/2022. We will be able to provide completion documentation in the form of employee signed participation sheets, and electronic records of completion on our internal tracking platform once the caregiver has finished their assigned trainings. These records will be kept in the 25/5 binder and updated annually to be in compliance with the required education and trainings.	
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 6/7/22 through 6/9/22. Monument Health Sturgis Care Center was found in compliance.	S 000		