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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, review of special droplet/contact precautions signage, review of Centers for Disease Control (CDC) publications, and policy review, the provider failed to ensure infection control procedures and practices were followed for: *Appropriate environmental controls to reduce or eliminate exposures to coronavirus disease 2019 (COVID-19) were implemented on one of two halls dedicated to caring for COVID-19 positive residents. *Appropriate hand hygiene and personal protective equipment (PPE) use by two of two observed housekeepers (C and D) while cleaning COVID-19 positive residents' rooms. Findings include: 1. Observation on 8/24/20 at 1:30 p.m. of hall 1 revealed: *It was located near the nurses' station and a walk way used by all staff. *There was a thin sheet of plastic that separated suspected COVID-19 positive residents' rooms 101 through 103 from positive COVID-19 rooms 104 through 114. -That plastic was secured to the ceiling and was open all the way down the middle. -One side of that plastic was taped half way down the south wall. -The opposite side of that plastic was not secured to the north wall. -Multiple strips of tape held that plastic together in one piece. *The bottom of the plastic was not secured to the floor. -It moved back and forth because of airflow. 2. Continued observation of hall 1 between 1:30 p.m. and 2:00 p.m. and again at 2:30 p.m. revealed four of the five occupied residents' room doors had been open. 3a. Observation on 8/24/20 at 1:35 p.m. of housekeeper C cleaning the first observed occupied COVID-19 positive resident room on hall 1 revealed: *He wore gloves, a surgical mask, and a face shield when he entered that room. *He exited that room after approximately three minutes of cleaning. -He stated, We gotta gown in every room. *Without removing his used gloves and performing hand hygiene he retrieved a clean gown from the PPE cart, put it on, and returned to that room to finish cleaning. b. Continued observation at 1:40 p.m. of housekeepers D and C in a second observed occupied COVID-19 positive room on that same hall revealed: *Without performing hand hygiene housekeeper D put on a gown and gloves before he entered that room. *Without performing hand hygiene housekeeper C put on gloves then pushed down accumulated trash inside a large garbage receptacle with his gloved hands. *He immediately put on a gown and entered the same room and began cleaning. c. Continued observation at 1:50 p.m. of housekeepers D and C in a third observed occupied COVID-19 room revealed: *Housekeeper C exited that room after it was cleaned, and removed his gown and gloves. *He adjusted his surgical mask under his face shield with that ungloved hand while holding a sack of garbage collected from that room. *Without performing hand hygiene he put on new gloves and a new gown before entering the next resident room. *Housekeeper D removed his gown and gloves after cleaning that same room. *He adjusted his surgical mask under his face shield with his ungloved hand and performed hand hygiene. 4. Interview on 8/24/20 at 1:00 p.m. with director of nursing (DON) A regarding hall 1 revealed: *The double-doors that led into that hall had been kept open. *The three residents' rooms inside those doors had been designated for residents with suspected COVID-19. -Those rooms had been unoccupied. *The remainder of rooms down that hall had been for COVID-19 positive residents. -There were seven residents in five of those rooms. *The plastic referred to earlier separated those distinct sections of that hall. Interview on 8/24/20 at 2:45 p.m. with DON A regarding COVID-19 positive residents' rooms revealed: *It was her expectation that staff followed the signage instructions posted outside those residents' rooms for hand hygiene and PPE use. *Resident room doors were not required to be closed on that unit. -Some residents preferred to have their doors open. Interview at that same time with senior director of long term care services B regarding the plastic that separated suspected COVID-19 residents from positive COVID-19 residents on hall 1 revealed: *He confirmed that plastic had not created an effective barrier between those units. *He agreed that double-doors leading into hall 1 should have been closed. *He stated he understood the COVID-19 residents' rooms should have been closed. Telephone interview on 8/26/20 at 1:00 p.m. with infection control nurse E regarding hall one revealed she: *Confirmed the plastic barrier referred to above was ineffective. *Stated the double-doors and residents' room doors should have been closed. -Those environmental controls had not been implemented. Review of the undated COVID-19 Risk Mitigation Plan revealed: *COVID-19 designated units (page 6 of 13): -2. Doors to the unit/room should be shut. -3. All room doors should remain shut on that unit to the extent that resident safety allows. Review of the updated 7/15/20 CDC publication Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic revealed: *Page 5 of 13: -Optimize the use of engineering controls to reduce or eliminate exposures by shielding healthcare providers and other patients (residents) from infected individuals. -Examples of engineering controls include physical barriers and dedicated pathways. Review of the undated Special Droplet/Contact Precautions signage outside resident rooms on hall one revealed: *Instructions for staff entering resident rooms. -Those instructions indicated staff entering those rooms must sanitize or wash hands, wear gown, wear gloves, wear eye protection, and wear a surgical mask. -Additional instructions included sanitizing or washing hands with soap and water when exiting the room. Review of the revised 6/25/20 CDC publication Preparing for COVID-19 in Nursing Homes revealed: *Page 5 of 9: -Care must be taken to avoid touching the respirator, facemask, or eye protection. If this must occur, HCP (healthcare provider) should perform hand hygiene immediately after touching PPE to prevent contaminating themselves or others.

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