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 _____	C 06/10/2025

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MONUMENT HEALTH STURGIS CARE CENTER	2140 JUNCTION AVENUE STURGIS, SD 57785

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 6/10/25. Areas surveyed included fall prevention interventions, potential staff to resident abuse, and potential staff to resident neglect. Monument Health Sturgis Care Center was found not in compliance with the following requirement: F610 and was found to have past non-compliance with the following requirement: F689.	F 000		
F 610 SS=G	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure one of one cognitively impaired sampled resident's (2) bruises of unknown origin had been	F 610	F610 Corrective Action 1.For the identification of and lack of provider failing to ensure one of one cognitively impaired sampled resident's (2) bruises of unknown origin had been thoroughly investigated to: Identify their root cause. Develop interventions to prevent or decrease the likelihood of them recurring. Rule out potential abuse or neglect all nurses were educated on 6/11/25, all unexplainable bruises should be reported as a variance to be investigated to determine their root cause and rule out potential abuse or neglect per the Resident Incidence/Variance Report policy. Resident (2) bruises were investigated, determined to be explainable bruises, and no abuse or neglect occurred. Resident (2) care plan was updated on 6/25/25 to read: " I am at risk for bruising r/t personal hx of bruising and Anticoagulant therapy AEB: personal history of TIA and cerebral infarction," with appropriate interventions tasked.	07/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Schmidt	President	07/03/2025

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 610	Continued From page 1 thoroughly investigated to: *Identify their root cause. *Develop interventions to prevent or decrease the likelihood of them recurring. *Rule out potential abuse or neglect. Findings include: 1. Observations on 6/10/25 at 8:30 a.m. and again at 9:30 a.m. of resident 2 revealed: *She sat in her wheelchair at a dining room table. She was assisted by staff to eat her breakfast. *A sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) was used to transfer her from the bathroom to a recliner in her room. -Staff had provided her basic instructions like "put your hands here" along with physical assistance to have the resident hold the handles of the lift while she was brought to a standing position. *The resident was able to answer simple yes and no questions, but she initiated no verbal interactions. Review of resident 2's electronic medical record (EMR) revealed: *Her admission date was 4/16/24. *Her diagnoses included diabetes, dementia (a group of symptoms affecting memory, thinking, and social abilities), heart failure, and depression. *Her 4/18/25 Brief Interview for Mental Status (BIMS) assessment score was five, which indicated she had severe cognitive impairment. *She required assistance from staff to complete all her activities of daily living. Review of resident 2's 4/30/25 through 5/28/25 weekly skin assessments revealed: *On 5/7/25: Skin injuries not found on the previous week's assessment had included:	F 610	2. Identification of Others All current and future residents are potentially affected by the deficiency of not ensuring one of one cognitively impaired sampled resident's (2) bruises of unknown origin had been thoroughly investigated to identify their root cause. Develop interventions to prevent or decrease the likelihood of them recurring. Rule out potential abuse or neglect. The facility will ensure future and current nursing staff will complete initial and annual education to ensure they are competent on providers Resident Incidence/Variance Report policy. Resident Incidence/Variance Report policy education will be tracked by the DON or designee to ensure completion. All identified education was provided to all specified staff, no later than 7/10/25, or before their next scheduled shift if unable to receive education prior to 7/10/25. 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.	

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F 610	Continued From page 2 "fading bruise to right inner knee, fading bruise to right LFA [lower forearm] and fading bruise right upper arm." *On 5/14/25: Skin injuries not found on the previous week's assessment had included:"Discoloration areas both arms-bruising above et [and] inside R/L [right and left] knee/front L thigh/upper outer L thigh..." *On 5/21/25: "Discoloration areas both arms-bruising above and inside R & L knee, front L thigh left hand, upper outer L thigh..." *On 5/28/25: "...has large dark purple bruises to LFA and RFA." -Purple-colored bruises were indicative of an injury that had occurred within the past one to two days. Those skin injuries would not have been found on the previous week's assessment. *On 6/4/25: "Resident has large bruises to RFA [right forearm] and LFA [left forearm]..." *The above skin assessments had: -No measurements of the resident's documented bruises. -Not defined what a "discolored" or "faded" bruise was. -Not indicated a cause or potential cause for the newly identified bruises. -Not indicated what was done to prevent additional bruises from recurring. Review of resident 2's care plan revealed: *She had the potential for pressure ulcer (injury to skin and underlying tissue from prolonged pressure) development related to incontinence, her history of a pressure ulcer that was present at the time of her admission to the facility, and a history of skin breakdown on her toes. *Her revised 5/1/25 skin interventions had included documenting weekly and as-needed skin checks completed by a nurse.	F 610	Monitoring: Audit tool has been created to focus on ensuring nursing staff within the facility are competent and understand a variance form must be completed for bruises that are documented as unexplained per the providers Resident Incidence/Variance Report policy. Audit tool has been created to focus on ensuring that when a variance report is completed due to an unexplainable bruise, the environment, cause/effect/prevention of events are reviewed and assessed. Alterations to the environment and/or plan of care implemented and adjusted as needed to decrease the risk of another event." per the providers Resident Incidence/Variance Report 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. (i.e. two quarterly QAPI meeting cycles)	

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F 610	Continued From page 3 -There was no indication she had a history of bruising or that she was at risk for frequent bruising. Interview on 6/10/25 at 2:05 p.m. with long term care (LTC) supervisor B regarding resident 2's bruises of unknown origin and the above weekly skin assessments revealed: *She thought resident 2 had bruised more easily because she was taking a blood thinning medication. *She had re-educated certified nurse aide (CNA) D recently for improperly transferring resident 2. *Nursing staff had not completed the above weekly skin assessments correctly. Nurses were expected to have: -Used the body outlines on the assessment to identify the places on the resident's body where there were skin injuries. -Measured each documented skin injury, described the color of the injury, and identified the known or possible cause of the skin injury and document that information in the resident's EMR. *Incidence/Variance reports were expected to have been completed by the nurse for any bruises of unknown origin that were identified during the resident's weekly skin assessments, but that had not occurred. *Completing an Incidence/Variance report would have: -Triggered an investigation to determine the root cause of resident 2's bruises. -Helped staff develop a plan for mitigating or preventing future bruises from recurring. -Identified if the bruises of unknown origin were caused by possible abuse or neglect. Incidence/Variance reports were requested from LTC supervisor B for resident 2's bruises of	F 610	DON or designee will report audit tool results to QAPI committee monthly. At which point the 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 education opportunities will be directed by QAPI committee in response to audit reports.	

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F 610	Continued From page 4 unknown origin documented on her 5/7/25, 5/14/25, and 5/28/25 skin assessments. LTC supervisor B stated no Incidence/Variance reports had been completed. Telephone interview on 6/10/25 at 3:50 p.m. with director of nursing (DON) A revealed she confirmed the expectations for the thorough completion of weekly resident skin assessments and the procedure for completing an Incidence/Variance report related to resident 2's bruises of unknown origin was not followed. Review of the provider's revised April 2025 Resident Incidence/Variance Reports policy revealed: *The types of variances that should be documented on that report had included bruises of unknown origin. *"3. c. The nurse initiating the investigation must complete the fall/abuse investigation report and turn into the Director of Nursing or designee." *"8. The environment, cause/effect/prevention of events are reviewed and assessed. Alterations to the environment and/or plan of care implemented and adjusted as needed to decrease the risk of another event."	F 610		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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F 689	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review, the provider failed to implement a fall prevention intervention to have a call light placed within the resident's reach to reduce the risk of falling for one of one sampled resident (1) who fell. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 6/6/25 submitted SD DOH FRI initial report regarding resident 1 revealed: *On 6/6/25, he was heard by staff calling out "Help me" from inside his room. -The resident was found on the floor by staff. He had stood himself up from his recliner and fallen as he reached for his call light. *A physical assessment of the resident was completed by a nurse. The resident's power of attorney and a physician were notified of his fall. -He was evaluated in the attached emergency room and he returned to the nursing home later that same evening. Observation on 6/10/25 at 8:30 a.m. in resident 1's room revealed: *He was asleep in his bed. -His call light was attached to the inside of the raised quarter side rail on the exit side of his bed, and was within his reach. 2. Observation on 6/10/25 at 9:30 a.m. of certified nurse aide (CNA) D and CNA E in resident 2's	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 6 room revealed they: *Transferred the resident from her bed to her recliner. -Ensured the resident's call light was within her reach before they exited the room. 3. Observation on 6/10/25 at 10:00 a.m. of CNA D and CNA E in resident 3's room revealed they: *Transferred the resident from her wheelchair to her bed. -Ensured the resident's call light was within her reach before they exited the room. 4. Observation and interview on 6/10/25 at noon with long term care (LTC) supervisor B in resident 1's room revealed: *The resident was asleep in his bed. His call light was within his reach. *His recliner sat across from the exit side of his bed. *His call light system was attached to the wall between the bed and the recliner. -The call cord split into two separate call lights. One was attached to the side rail on his bed and a second call light would be accessible to the resident when he would sit in his recliner. *The provider's investigation of resident 1's 6/6/25 fall had concluded CNA F failed to ensure the resident's call light was within his reach after he was positioned in his recliner earlier that evening. -LTC supervisor B stated that failure was identified as the root cause of resident 1's fall. *He made his needs known by using his call light and by calling out for staff assistance and not using his light. Review of CNA F's personnel file revealed: *Her hire date was 5/27/25. *She had been a CNA since 6/3/19 and her CNA	F 689		

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F 689	Continued From page 7 certification was current. *Her orientation checklist indicated on 5/27/25 that she had been educated regarding the provider's Fall policy. *She had completed her Safety and Quality training on 5/28/25. Telephone interview on 6/10/25 at 3:35 p.m. with director of nursing (DON) A revealed: *CNA F was counseled regarding fall prevention expectations on 6/6/25 by registered nurse C after resident 1 had fallen. *A detailed corrective fall prevention action plan would be identified in the provider's SD DOH FRI final report. The provider's implemented actions to ensure the deficient practice does not recur was confirmed onsite on 6/10/25 after observations and interviews revealed the facility had followed their quality assurance process and: *Counseled CNA F regarding ensuring resident call lights were accessible for them to activate. *Random observations confirmed call lights had been positioned within the resident's reach after caregivers exited residents' rooms. *There was a plan to include the following in the provider's SD DOH FRI final report: -Re-education of all staff regarding resident safety and expected fall prevention interventions. -Implementation of audits to ensure that staff were consistently positioning all resident's call lights within their reach before exiting resident rooms. -Reporting to the Quality Assurance (QA) committee the above audit findings. Based on the above information, non-compliance at F689 occurred on 6/6/25, and based on the	F 689		

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F 689	Continued From page 8 provider's implemented corrective actions on 6/6/25 and additional corrective action plans, for the deficient practice confirmed on 6/10/25, the non-compliance is considered past non-compliance.	F 689		