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 _____	C 11/15/2023

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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 11/15/23. The area surveyed was resident neglect. Monument Health Sturgis Care Center was found not in compliance with the following requirement: F689.	F 000		
F 689 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on closed record review, job description review, interview, and policy review, the provider failed to ensure fall management and documentation protocols had been followed after one of one closed record sampled resident (1) had fallen. Findings include: 1. Review of resident 1's closed record revealed she: *Admitted to the nursing home on 10/16/23. *Had fallen in the assisted living center (ALC) where she was residing and sustained a right hip fracture and right humerus fracture. -Was able to bear weight on her lower extremities as tolerated but was non-weight bearing to her right arm. -Had hip precautions which included no leg	F 689	Corrective Action: The deficiency for resident 1 was corrected by completing an incident report to the SD DOH on November 6th, 2023, regarding this incident. Areas of concern were identified in the conclusion of this report and areas of concern were addressed. CNA C and LPN D were both counselled to ensure that both the Fall policy and communication value of trust, asking for help when needed and communicating in ways that others understand were followed moving forward. Resident 1 was discharged from the facility on November 6th, 2023, and did not return to facility. Identification of Others: All current and future residents are potentially affected by the deficiency regarding fall management and documentation protocols findings related to resident 1. Fall policy reviewed with all CNA's and Licensed Nursing staff on November 20th, 2023.	12/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Schmidt — TITLE — (X6) DATE: 11-27-2023

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.

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F 689	Continued From page 1 crossing, no bending past 90 degrees, and avoiding lower extremity rotation. *Had severe cognitive impairment including limited safety awareness and the inability to make her needs known. *Had fallen in the nursing home at 7:30 p.m. on 11/3/23. Telephone interview on 11/15/23 at 9:20 a.m. with certified nurse aide (CNA) C revealed she: *Assisted resident 1 to the bathroom in her room on the evening of 11/3/23. -Left the resident in the bathroom while she had retrieved peri-care supplies from the resident's dresser. *Observed the resident exit the bathroom, turn right towards her nightstand, and reach for candy in a bowl on top of the nightstand. -Was unable to reach the resident before she had fallen to the floor onto her right side. *Moved the resident from the floor and "got her comfortable" in her bed. *Notified licensed practical nurse (LPN) D of the fall. *Was aware after the resident had fallen she should have: -Ensured the environment and the resident was safe. -Not moved the resident. -Immediately notified the nurse that the resident had fallen. Telephone interview on 11/15/23 at 2:30 p.m. with LPN D regarding the fall referred to above revealed she: *Was assisting resident 1's roommate when CNA C had informed her resident 1 was in pain "or something." -The pain occurred when resident 1 was rolled	F 689	Fall policy will be reviewed again at the staff meeting on December 5th for all nursing department staff. All identified education was provided to all specified staff as no later than 12/30/23, or before their next scheduled shift if unable to receive education prior to 12/30/23. System Changes: Root cause analysis conducted answered the 5 whys: *For the identification of lack of fall management and documentation protocols. CNA moved resident prior to a Nurse coming to assess post fall. Intervention, corrective action will be completed as needed. Nursing staff did not bring adequate supplies with them when toileting residents. Intervention, education for all nursing staff to ensure adequate supplies are there when starting cares and if needed ask for assistance from another caregiver by using the call light.	

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F 689	Continued From page 2 onto her side. *Had not previously met resident 1 but was aware she had a repaired hip fracture. *Visually assessed the resident and when she touched her observed no moaning or flinching. *Noticed resident 1's right foot was "inverted in" and looked like it was in an "unnatural position." -Asked CNA C if the resident's foot had "always looked that way" and CNA C replied it had. *Asked CNA C whether or not the resident had fallen. -When CNA C said she "yes" she had fallen, LPN D was uncertain if CNA C had meant resident 1 had fallen prior to coming to the nursing home or that she had meant the resident had fallen that evening. -Failed to ascertain in her conversation with CNA C when the resident had fallen. *Had not contacted the on-call nurse manager or the on-call medical provider after her conversation with CNA C and her observations of resident 1's foot referred to above. -Agreed that given resident 1's recent hip fracture, CNA C's report, and her observation of the resident's foot, the resident might have re-injured her hip. *Waited until shift change the morning of 11/4/23 to report to the oncoming registered nurse (RN) E her observation referred to above regarding resident 1's foot. *Should have documented the resident assessment referred to above and initiated and/or completed the required fall and post-fall documentation. Interview on 11/15/23 at 10:00 a.m. with RN E revealed: *During the 6:00 a.m. to 6:00 p.m. shift on 11/4/23 CNA D reported that resident 1 had fallen in her	F 689	Nursing staff did not communicate effectively with each other. Intervention, education for all nursing staff to communicate effectively and ask additional questions when unsure of any situation. Nursing staff did not reach out to on call supervisor when unsure of what to do. Intervention, education for all nursing staff to follow chain of command and the on-call supervisor option. Nursing staff unaware of fall management and documentation policy. Intervention, education for all nursing staff on fall policy on hire. Monitoring: Audit tool has been created to focus on fall policy is being followed for residents that have fallen. The Fall policy audit tool will continue for a minimum of 6 months. (i.e. two quarterly QAPI meeting cycles) at which point the decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee.	

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F 689	Continued From page 3 room the previous evening. -CNA D had notified LPN D of that fall. *RN E completed an assessment of resident 1 while the resident sat on the edge of her bed. -That assessment was negative for any unusual findings and the resident was in no apparent pain at that time. *RN E should have completed the following: -Documented her assessment of resident 1 referred to above. -Completed the required post-fall documentation. *RN E contacted the on-call nurse manager (nurse supervisor B) on 11/4/23 and notified her of resident 1's 11/3/23 fall. --Nurse supervisor B advised RN E to wait for LPN D to arrive for her scheduled shift that same night and have her initiate and complete the fall and post-fall documentation. Interview on 11/15/23 at noon with nurse supervisor B revealed she: *Had not followed-up with LPN D until three days after the resident's fall on 11/6/23 and determined no fall or post-fall documentation had been completed. *Should have notified resident 1's family and her medical provider about resident 1's fall after she had been informed about it on 11/4/2. Review of resident 1's closed record and interview on 11/15/23 at 12:40 p.m. with director of nursing (DON) A and nurse supervisor B revealed: *They spent the morning of 11/6/23 trying to locate resident 1's 11/3/23 fall documentation and speak with CNA C and LPN D regarding that fall prior to notifying her family about what had happened. *After physical therapist F noticed resident 1 had	F 689	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 fall policy is being followed for any resident that has fallen in the 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.	

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F 689	Continued From page 4	F 689		

a right leg length discrepancy around 11:00 a.m. on 11/6/23 she notified resident 1's medical provider of her findings, and an x-ray was ordered.
*At 1:28 p.m. resident 1's family contacted the facility after they had received a notification from a healthcare patient portal system advising them of resident 1's x-ray results.
*Around 2:08 p.m. the resident was transferred to the local emergency department for further evaluation of a displaced right hip.
*DON A confirmed:
-Required fall and post-fall documentation that included the Fall Scene Investigation Report (Resident Incident/Variance Report Form), a risk management report, 72-hour post-fall assessments and progress notes, and Treatment Administration Record (TAR) charting of resident 1's 11/3/23 fall was not completed.
-Resident 1's family and medical provider should have been notified by LPN D of resident 1's 11/3/23 fall "immediately" or "in a timely fashion".

Review of the 6/15/23 LPN job description revealed:
*Values the LPN was expected to uphold included trust.
-That was achieved by "Asking for help when needed and communicating in ways that others understand."

Review of the provider s revised May 2021 Fall Prevention/Management/Documentation policy revealed:
*Management of a fall:
-"3. Do not move the resident until their status has been completely evaluated."
-"6. If a deformity or injury is noted, call the physician for approval for transport by ambulance

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F 689	Continued From page 5 to the hospital." -"14. Notify the attending physician of the fall ..." -"16. Notify the resident family or POA [power of attorney] of the incident." *Documentation of a fall: -"1. Complete the Resident Incident/Variance Report Form. Include investigation to rule out abuse/neglect, interview process CNA will complete initial investigation form, Primary nurse will complete initial investigation form. "3. Each shift is to assess and chart in the Interdisciplinary Progress Notes for 72 hours after any fall whether resulted in injury or no injury. "4. Place nursing order on TAR (treatment administration record) fall documentation every shift X 3 days."	F 689		