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	02/19/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43844 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and policy review, the provider failed to ensure one of one allegation of controlled (medication with risk for abuse and addiction)medication diversion was reported within the required time frame. Findings include: 1. Review of the provider's 2/5/25 SD DOH FRI regarding resident 1 revealed: *On 1/31/25 two tablets of oxycodone (a controlled pain medication) were found by registered nurse (RN) B in an unoccupied room. *On 2/3/25 at approximately 3:00 p.m. RN B notified director of nursing (DON) A that resident 1's as needed medication card of oxycodone could not be located. *On 2/3/25 DON A confirmed the card of oxycodone was unable to be located and initiated an internal investigation with the provider's drug diversion team. *On 2/5/25 DON A confirmed resident 1's card of oxycodone, and that medication's controlled medication count sheet was not accounted for. * On 2/5/25 at 9:24 a.m. DON A filed a SD DOH FRI and notified law enforcement. 2. Interview on 2/19/25 at 10:28 a.m. with DON A revealed: *On 1/31/25 RN B found two tablets of oxycodone in an unoccupied room. *Who the oxycodone belonged to was unable to be determined. *On 2/3/25 at 2:30 p.m. or 3:00 p.m. RN B notified DON A that she was unable to locate resident 1's card of oxycodone. *DON A notified the consultant pharmacist and the facility's drug diversion team. *On 2/4/25 DON A had been unable to locate the card of oxycodone. (continued on next page)

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.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*On 2/5/25 DON A notified law enforcement and completed the SD DOH FRI because she had not located Resident 1's card of oxycodone. *She was able to account for all of the residents' controlled medication cards. *She audited resident 1's past controlled medication logs and determined there were three logs that were not able to be accounted for. -A medication log for a medication card that contained 30 tablets of oxycodone that was prescribed to be administered as needed from 6/3/24. -A medication log for a medication card that contained seven tablets of oxycodone from 8/3/24. -A medication log for the medication card that contained 30 tablets of oxycodone from 1/20/25. *She audited one other resident's controlled medication logs and was unable to locate one medication log for that resident. *On 2/5/25 she initiated a new procedure to account for controlled medication cards and controlled medication logs under the recommendation of the consultant pharmacist. *On 2/10/25 she emailed the facility staff education on the new procedure related to the controlled medication cards and logs. Interview on 2/19/25 at 5:35 p.m. with DON A revealed: *She was unsure when the oxycodone went missing. *She was responsible for filing the report to the SD DOH. *She did not report the missing card of oxycodone on 2/3/25 because she was not sure it was missing. 3. Review of the provider's 2/2025 Abuse Prevention/Intervention, Investigation, Complaints, Grievances & [and] Reporting policy revealed: *It is the policy of [the provider] to develop a process to receive grievances and complaints, respond timely to filings and reporting dispositions to residents as described by South Dakota Department of Health Regulations. The following definitions are provided to assist all persons in recognizing incidents of abuse and are applicable to all residents regardless of their age, disability, or ability to comprehend. -THEFT/MISAPPROPRIATION OF RESIDENT PROPERTY is defined as the pattern or deliberate misplacement, exploration, or wrongful, temporary or permanent use of resident's belongings or money without the resident's consent. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The provider Will notify Department of Health (DoH) that an abuse investigation is being conducted within 48 hours of caregiver becoming aware of the alleged incident. *An initial written report of abuse and any witness statement(s) are provided to DoH within twenty-four (24) hours of the reporting of occurrence of such incident. *Should investigation reveal that a false report was made/filed, the investigation shall cease.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51472 Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to: *Ensure prescribed pain medication was acquired and administered in a timely manner for one of one resident (1) who had pain. *Maintain records to account for controlled (medications with risk for abuse and addiction) medications according to the provider's policy. *Ensure proper documentation and destruction of medications according to the provider's policy. Findings include: 1. Review of the provider's 2/5/25 SD DOH FRI regarding resident 1 revealed: *On 1/31/25 two tablets of oxycodone (a controlled pain medication) were found by registered nurse (RN) B in an unoccupied room. *On 2/3/25 RN B notified director of nursing (DON) A that resident 1's as needed medication card of oxycodone could not be located. *On 2/5/25 DON A confirmed resident 1's card of oxycodone and that medications' controlled medication count sheet was not accounted for. *An audit of the controlled medication count sheets was completed and identified two additional controlled medication sheets, in the past year that were unable to be located. 2. Observation on 2/19/25 at 8:57 a.m. of the [NAME] hallway treatment cart revealed: *There was a book labeled controlled substance on the cart. *That book contained a form labeled Shift Audit Record and individual Controlled Drug Administration Records identified with pharmacy labels. *There were times identified beside each date on the Shift Audit Record. *The times were 0600 (6:00 a.m.) and 1800 (6:00 p.m.). *Beside each time were two columns titled Signature of Nurse Leaving Shift and Signature of Nurse Coming on Shift. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The bottom of the shift audit record indicated Signing acknowledges that you have counted the controlled medication on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the Controlled Drug Administration Record. *The current shift audit record was started on 2/12/25. *On 2/13/25 beside 0600 there was no signature in the nurse leaving shift column. *On 2/19/25 in the 1800 area a signature was present in the nurse leaving the shift column. Interview on 2/19/25 at 9:00 a.m. with licensed practical nurse (LPN) E revealed: *She was administering medications on the [NAME] hallway. *The shifts for nurses were from 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m. *The shift audit record was to be signed by the oncoming nurse and the outgoing nurse. *The signatures indicated that the controlled medication counts were correct. *She stated the nurse leaving shift signature in the 2/19/25 1800 column was her signature. *She had not counted the controlled medication with the oncoming nurse prior to signing the shift audit record. 3. Observation on 2/19/25 at 9:57 a.m. of the Berry hallway treatment cart revealed: *There was a book labeled controlled substance on the cart. *The book was organized the same way as the controlled substance book on the [NAME] hallway treatment cart. *The current shift audit record was started on 2/10/25. *On 2/19/25 in the 1800 area, a signature was present in the column for the nurse leaving the shift. *There was an oxycodone medication card for resident 1, labeled for as needed use, with a received date of 2/10/25. 4. Observation on 2/19/25 at 10:05 a.m. of the Berry hallway medication cart revealed: *A card of oxycodone 5mg (milligrams) tablets for resident 1. *Each tablet was secured into a bubble with a foil backing. *The bubble numbered 25 had a punctured foil backing and the tablet was secured in the bubble with clear tape. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Interview on 2/19/25 at 10:05 a.m. with unlicensed medication aide (UMA) D revealed: *Controlled medications that were scheduled to be administered were stored in the medication carts in the [NAME] and Berry halls. *Controlled medications that were to be administered as needed were stored in the treatment carts in the [NAME] and Berry halls. *The nurses had the keys to open those treatment carts. *The nurses administered the as needed controlled medications. *At 8:00 a.m. that morning (2/19/25) she had mistakenly punched out resident 1's oxycodone from the card. *She had placed the oxycodone tablet back into the card and secured it in the bubble with tape. *She had not notified anyone that she had mistakenly punched out and secured the oxycodone tablet in the card with tape. 6. Observation on 2/19/25 at 10:05 a.m. of the [NAME] hallway medication cart revealed: *A controlled substance book that was organized the same as the ones on the treatment carts. *The times beside the dates on the Shift Audit Record were titled 6-2 (6:00 a.m. to 2:00 p.m.), 2-10 (2:00 p. m. to 10:00 p.m.), and 10-6 (10:00 p.m. to 6:00 a.m.). *The current shift audit record was started on 2/12/25. *On 2/13/25 beside the 6-2 time there was no signature in the nurse leaving the shift column. *On 2/19/25 in the 2-10 area, a signature was present in the nurse leaving the shift column. 7. Observation on 2/19/25 at 9:30 a.m. of the medication room revealed: *There was a Stericycle container and a lock box on the wall. *There was a [NAME] (a container for hazardous waste) on the floor. *The Medication Destruction Log was on the counter. 8. Interview on 2/19/25 at 12:50 p.m. with DON A revealed: *She had been checking the controlled medication cards since Resident 1's oxycodone card was located but she did not have a formal audit in place. *The consultant pharmacist had been to the facility on [DATE] and completed a random controlled medication audit with all controlled medications accounted for. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Interview on 2/19/25 at 3:25 p.m. with resident 1 revealed: *She had pain related to having had a back surgery and arthritis. *Her pain was controlled by the pills she was given. *Her pain was most often in her back and down her left leg. *If she had pain, she would ask for a pain pill. *She stated that she was unsure if she could receive an as needed pain medication at that time because she was told the provider was waiting for the doctor. 10. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *Her 12/27/24 Brief Interview of Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. *Her diagnoses included: Chronic pain, Rheumatoid arthritis, osteoarthritis, contracture left hand, pain in left knee, depressive disorder, anxiety, and pain in her right shoulder. *Her physician orders included: -Acetaminophen 650 mg [milligrams] 3x [three times] day for chronic pain - 0000 [midnight], 0800 [8:00 a.m.], and 1600 [4:00 p.m.] - don't [do not] change times NP [nurse practitioner] would like these staggered with other scheduled pain meds. -Oxycodone HCl 5 MG 3x day for chronic pain - do not change times this is per the NP order- 0600 [6:00 a.m.] 1200 [noon], and 1800 [6:00 p.m.]. -Oxycodone HCl 5 MG every 24 hours as needed for pain related to rheumatoid arthritis. Review of resident 1's 2/19/25 care plan revealed: *There was a focus area related to pain management with a goal to not have interruption in normal activities due to pain. *Identified interventions for that goal included: -Anticipate my need for pain relief and respond immediately to any complaint of pain. -I am able to: call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increases or alleviates pain. Review of resident 1's nurse progress notes revealed: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*On 2/2/25 at 5:27 a.m. a late note was entered by LPN F -The effective date and time of that late note were indicated as 2/1/25 at 10:25 p.m. -The progress note indicated, Resident yelling out and crying. C/O [complaint of] back pain 10/10 [on a zero to ten pain scale]. Midnight Tylenol given now as no PRN [as needed] oxy [oxycodone] available. 11. Interview on 2/19/25 at 3:44 p.m. with DON A regarding resident 1's pain management revealed: *She had not been made aware resident 1's as needed oxycodone was not available on 2/1/25. *The nurse could have called the on-call provider in the hospital to obtain a prescription. *With the prescription, the nurse could have obtained a code to remove an emergency dose of that prescribed pain medication from the automated medication dispensing cabinet to administer to resident 1. *She was not aware resident 1's replacement as needed oxycodone medication card had not arrived until 2/10/25. 12. Review of the controlled medications shift audit records from 10/1/24 through 2/9/25 revealed: *The shift audit records were labeled as narcotic count sheets. *The times beside the dates on those audit records for the Berry and [NAME] medication carts were listed as 0600 (6:00 a.m.), 1400 (2:00 p.m.), and 2200 (10:00 p.m.). The column of incoming and outgoing staff signatures referenced a Med Aide (UMA). *The times on the audit record for the Berry and [NAME] treatment carts were listed as 0600 and 1800 (6:00 p.m.). *There were no shift audit records for the Berry medication cart from 10/10/24 through 11/13/24. *There were no signatures : -On 11/28/24 at 1400 for the incoming and outgoing UMA. -On 1/11/25 at 1400 for the outgoing UMA. -On 2/3/25 at 1400 for the incoming UMA. -On 2/8/25 at 0600 for outgoing UMA. *There were no signatures on the shift audit records for the [NAME] medication cart. -On 11/6/24 at 2200 for the incoming UMA. -On 11/7/24 at 0600 for the outgoing UMA. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 12/1/24 at 2200 for the incoming UMA. -On 12/2/24 at 0600 for the outgoing UMA. -On 12/13/24 at 1400 for the outgoing UMA. -On 12/14/24 at 2200 for the incoming UMA. -On 12/15/24 at 0600 for the outgoing UMA. -On 12/23/24 at 0600 for the incoming UMA and 1400 for the outgoing UMA. -On 12/26/24 at 2200 for the incoming UMA. -On 1/6/25 at 2200 for the incoming UMA. -On 1/7/25 at 0600 for the outgoing UMA. -On 1/17/25 at 1400 for the incoming UMA and 2200 for the outgoing UMA. -On 1/19/25 at 0600 for the incoming UMA and 1400 for the outgoing UMA. *There were no signatures on the shift audit records for the [NAME] treatment cart on 11/17/24 at 1800 for the incoming nurse. *There were no signatures on the shift audit records for the Berry treatment cart: -On 10/8/24 at 1800 for the incoming nurse. -On 10/28/24 at 1800 for the incoming nurse. -On 12/6/24 at 0600 for the incoming nurse and 1800 for the outgoing nurse. -On 12/31/24 at 0600 for the incoming nurse and 1800 for both the incoming and outgoing nurse. -On 1/1/25 at 0600 for both the incoming and outgoing nurse. -On 1/4/25 at 1800 for the incoming nurse. -On 1/5/25 at 0600 for the outgoing nurse. 13. Interview on 2/19/25 at 5:35 p.m. with DON A revealed: * She was unable to locate the shift audit records from 10/19/24 through 11/13/24. *It was her expectation that the controlled substances be counted between each shift by the outgoing and incoming UMA and nurses. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*If a single medication was refused by a resident or for some other reason was not administered after it was removed from the bubble pack two nurses were to destroy the medication by putting the medication in the Stericycle (a container used to dispose of pharmaceutical waste) and document the destruction. *A medication should not be returned and secured with tape once removed from the bubble pack. *She was aware that there were signatures that were missing on the shift audit report but was not aware that the UMAs and nurses were signing the forms prior to completing the controlled medication count between shifts. *She was not aware that resident 1's as needed oxycodone had not arrived at the facility until 2/10/25. *She had reordered the as needed oxycodone replacement card on 2/5/25. *There were three methods of disposal for medications, the mailbox, the Stericycle container, and the [NAME]. *Controlled substances were not to be disposed of in the [NAME]. *When medications were destroyed two nurses documented the destruction unless the medication was a controlled substance then two nurses were to indicate the method for destruction was the mailbox and the two nurses would then sign in the column Destroyed by 2 Individuals Name/Name and the controlled substance would later be destroyed by the DON and the pharmacist. *If there was a single dose of a controlled substance that needed to be destroyed it could be placed in the mailbox or two nurses could destroy the medication in the Stericycle. *She indicated Lyrica should not have been destroyed in the [NAME]. *The [NAME] did not prevent someone from retrieving a medication that was disposed in it. *The [NAME] did not alter the texture, taste, or consistency of the medication that was disposed in it. *Medications should not be placed in the sharps container as a method for destruction. Review of the provider's 2/24 Drug Diversion Policy revealed, All controlled substances will be counted every shift and documentation signed for oncoming and off-going nurse and/or medication aid. 14. Review of the providers Medication Destruction Log revealed: *Oxycodone (a controlled pain medication) 5mg, one tablet, was wasted in a sharps container (a puncture-resistant container used to dispose of sharp instruments and needles) on 10/18 and 11/22. *Fourteen vials of Haldol (an antipsychotic medication) were wasted in a sharps container on 2/10/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Lyrica (a controlled pain medication) was wasted in a [NAME] on 2/16/25 and 2/18/25. *There were no prescription numbers Review of the provider's 02/2024 Security, Destruction, Return and Logging of Medications/Drugs policy revealed: *1. A Drug Destruction Log will be completed when medications are destroyed or returned to the dispensing pharmacy. *2. A separate Drug Destruction Logs must be completed for each of the following: controlled, uncontrolled, and returned medication. *3. Each resident must have their own Drug Destruction Log for the destruction of Controlled Medications and their own Drug Destruction Log for the destruction of non-controlled and schedule V unit dose drugs. *5. For controlled medications/drugs (schedule II, III, IV), an RN and Pharmacist are responsible for witnessing the drug destruction and ensuring that the following information (5a-5i) is correctly entered on the Drug Destruction Log. a. Resident's name b. Date drug destroyed c. Prescription number d. Name of drug e. Strength of the medication f. Quantity of medication destroyed g. Method of destruction h. Reason for destruction i. Signature of witness *7. Drug Destruction Logs and Drug Return Logs serve as the documentation record for destroyed or returned medications. *8. Drug Destruction Logs are kept on file in the facility in the Drug Destruction Log binder until the resident is discharged from the facility. The Drug Destruction Log is then placed in the resident's closed clinical record. 51816

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51816 Based on observation, interview, and policy review, the provider failed to ensure expired medications were removed from two of two medication carts and one of two treatment carts. Findings include: 1. Observation on 2/19/25 at 9:00 a.m. of the [NAME] hallway treatment cart revealed multiple medications that were past their expiration dates. Medications that were expired included: *Resident 2's card of 30 tabs of Hydrocodone/acetaminophen 5/325 (opioid pain reliever) on 12/24. *Resident 13's Novolog insulin pen had no date written on it to indicate the date it was opened. *Resident 5's CalProtect ointment (used to treat minor skin irritations) on 11/24. *Resident 8's Nystatin powder (used to treat fungal or yeast infections) on 1/6/25. *Resident 6's Nystatin powder on 2/7/25. *Resident 6's CalProtect ointment on 7/8/24. *Resident 7's Ketoconazole ointment (used to treat fungal infections) on 3/20/24. *Resident 10's Nystatin powder on 1/29/25. *Resident 14's Diclofenac gel (used to treat pain and swelling) on 12/26/24. *Resident 13's Tacrolimus ointment (used to treat eczema) on 12/10/24. *Resident 12's Nystatin powder on 10/17/24. *Resident 11's Ciclopirox topical solution (used to treat fungal infections) on 8/15/24. *Resident 9's Nitroglycerin tablets (used to treat chest pain caused by coronary artery disease) on 2/14/25. 2. Observation and interview on 2/19/25 at 9:57 a.m. of the Berry hallway medication cart with registered nurse (RN) C revealed: *Resident 3's Latanoprost eye drops (used to treat glaucoma) had no date written on it to indicate the date it was opened. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Health Sturgis Care Center	2140 Junction Avenue Sturgis, SD 57785

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*He stated checking expiration dates was not a task assigned to a specific nurse or shift, and they were to look at expiration dates before administering medications. *Medications should be dated when they are opened. *Not all medications were dated when opened. *Latanoprost was a medication with a shortened expiration date that needed to be dated when opened. 3. Observation on 2/19/25 at 10:24 a.m. of the [NAME] hallway medication cart revealed: *Resident 4's Latanoprost eye drops had no date written on it to indicate the date it was opened. -The pharmacy label indicated the refill had been issued on 12/5/24. 4. Interview on 2/19/25 at 4:15 p.m. with licensed practical nurse (LPN) E regarding the medications in the [NAME] hallway treatment cart revealed: *She confirmed resident 13's Novolog insulin pen had no date to indicate when it had been opened. *She confirmed the location of expiration dates was on the medication labels. 5. Interview on 2/19/25 at 5:39 p.m. with director of nursing (DON) A regarding expiration dates revealed she expected nurses and unlicensed medication aides to date a medication when it was opened. 6. Review of the provider's undated Abridged List of Medications with Shortened Expiration Dates revealed: *Latanoprost has a shortened expiration date of, 6 weeks (42 days) after opening or moving to room temp. [temperature]. *Novolog has a shortened expiration date of, 28 days after accessing insulin for first use. 7. Review of the provider's 2/25 Expiration of Medications policy revealed: All 'time-dated' medications have an expiration date printed on the container. If the manufacturer's date occurs before the expiration date based upon date of opening, the earlier of the two is to be followed.