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	03/19/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and policy review, the provider failed to ensure the staff followed infection prevention and control practices regarding:*Hand hygiene (handwashing) and glove use by one of one registered nurse (RN) (E) during resident blood sugar level testing (measuring the amount of sugar in the blood using a glucometer or a blood glucose meter) for one of one sampled resident (29), and by one of two certified medication aides (CMA) (F) during medication administration for one of three sampled residents (24).*Hand hygiene and no gown use by one of one RN (E) during wound care for one of one sampled resident (13). Findings include:1. Observation on 3/17/26 at 8:10 a.m. of RN E revealed with her gloved hands, RN E used the computer keyboard and mouse to review resident 29's medication administration record (MAR), then opened the medication cart to retrieve a glucometer, glucose test strip, packaged alcohol pads, and a lancet. RN E closed the medication cart and the computer screen, and walked into resident 29's room. With those same gloved hands, she inserted the test strip into the glucometer, wiped resident 29's finger with an alcohol pad, pricked his finger with the lancet, applied a drop of blood from the resident's finger to the test strip, wiped the finger again with another alcohol pad, and waited for the blood sugar level reading. RN E exited the resident's room and returned to the medication cart. She removed and discarded her gloves, performed hand hygiene, then disinfected the glucometer before placing it back inside the medication cart. 2. Interview on 3/17/26 at 12:10 p.m. with RN E regarding the above observation revealed she should have removed and discarded her gloves, performed hand hygiene, and put on a pair of clean gloves before she checked resident 29's blood sugar level to mitigate the risk of cross-contamination. 3. Interview on 3/19/26 at 9:38 a.m. with director of nursing (DON) B regarding infection control practices related to checking the resident's blood sugar levels revealed RN E should have performed hand hygiene and put on a pair of clean gloves before checking resident 29's blood sugar. 4. Review of the provider's undated Glucometer Competency Checklist revealed a staff member Understands the need for Personal Protective Equipment (PPE) and performs hand hygiene before performing the blood sugar check. 5. Observation on 3/18/26 at 8:35 a.m. of CMA F revealed she performed hand hygiene before preparing resident 24's medications for administration. CMA F had clear-colored medical tape around the top of her fourth finger on her left hand and the third finger on her right hand. Using her bare hands with those two taped fingers, she touched individual pills when she pushed them out of ten medication blister packs into the medication cup. CMA F periodically applied an alcohol-based hand sanitizer (ABHS) while she prepared resident 24's medications for administration. (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

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	03/19/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Observation and interview on 3/18/26 at 9:00 a.m. after CMA F administered resident 24's medications revealed CMA F stated there was no medical reason for why she had taped her fingers. She removed the medical tape from her fingers, acknowledged that the tape was discolored and unclean, and that she had touched some of the medications she had administered to resident 24 with those taped fingers. 7. Interview on 3/19/26 at 9:40 a.m. with DON B regarding the above medication administration observation revealed that resident 24's medications were expected to be pushed out of their blister packs directly into the medication cup, preventing the need to physically touch medications. The medical tape was an uncleanable surface (a material that cannot be sanitized or cleaned). The tape should not have been worn for non-medical reasons. If the tape was necessary, glove use was expected to prevent the potential for cross-contamination occurring. 8. Observation on 3/18/26 at 11:05 a.m. with RN E in resident 13's room revealed RN E performed hand hygiene, put on a pair gloves, and prepared clean supplies to perform the resident's wound care. RN E removed the unclean wound dressing from resident 13's gluteal fold and discarded that dressing in the trash can. RN E removed her gloves and discarded them in the trash can, performed hand hygiene and put on a new pair of gloves. She then used the cleaning supplies to clean resident 13's open wound. After cleaning that open wound, RN E picked up a piece of hydrogel dressing (a specialized dressing that maintains a moist healing environment) from the clean supplies and placed that hydrogel dressing to the wound using a cotton-tipped applicator. RN E covered that dressing with a foam dressing with adhesive dressing to keep the hydrogel in place. She discarded the unclean wound supplies in the trash can, removed her gloves, discarded them in the trash can, and then performed hand hygiene. 9. Interview immediately after the above dressing change observation with RN E revealed she acknowledged that the gloves she was wearing were considered dirty after directly touching resident 13's open wound. RN E acknowledged that she did not wear a gown while performing the resident's wound care. She was aware of the sign for enhanced barrier precautions hanging on the wall outside of resident 13's room that instructed the staff to wear a gown and gloves while performing wound care. 10. Review of resident 13's electronic medical record (EMR) revealed that nursing staff documented a Stage II pressure injury to her left intergluteal cleft (groove between the buttocks) on 1/15/26 that measured 0.4x0.3x0.2cm (centimeters). She was placed on an air mattress, a chair cushion, and a physician's order was documented on how the staff were expected to treat that wound. 11. Interview on 3/19/26 at 10:59 a.m. with DON/infection preventionist B revealed she expected the staff to perform hand hygiene after cleaning a resident's wound and before putting on new pair of gloves. She also expected the staff to follow instructions on the enhanced barrier precautions sign, which included the staff were to wear a gown when performing high-contact care such as wound care. 12. Review of the provider's enhanced barrier precautions sign revealed that there were three sections to the sign. Under the everyone must section of the sign, everyone was expected to clean their hands, including before entering and when leaving the room. Under the providers and staff must also section of the sign, they were expected to wear gloves and a gown following high-contact resident care activities. There was a list under that section of the sign that included wound care: any skin opening requiring a dressing. (continued on next page)

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	03/19/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. Review of the provider's 4/2024 hand hygiene policy revealed staff were expected to perform hand hygiene after contact with body fluid or excretions, mucous membranes, non-intact skin, and wound dressings and before preparing or handling medications.

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	03/19/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, and policy review, the provider failed to follow professional standards regarding one of one registered nurse (RN) (E) who provided a Trelegy Ellipta (a medication to improve lung function) inhaler (a portable device for administering a medication that is breathed into the lungs) to one of one sampled resident (43) who did not have a physician's order or a medication self administration assessment completed for the inhaler and was observed self administering the medication. Findings include: 1. Observation and record review on 3/18/26 at 9:00 a.m. of RN E preparing resident 43's Trelegy Ellipta inhaler for administration revealed she compared the prescription label on the inhaler box to the physician's order in the resident's medication administration record (MAR). The instructions for use of that inhaler indicated: 1 puff, inhale orally one time a day .RN E cleaned her hands with an alcohol-based hand sanitizer, brought the inhaler into the resident's room, and handed the inhaler to resident 43. She self-administered one puff from the inhaler. The resident then swished water into her mouth and spit it out in a basin before handing the inhaler back to RN E to return to the medication cart.2. Review of resident 43's electronic medical record (EMR) revealed a medication self-administration assessment completed by director of nursing (DON) B on 3/6/26, which assessed resident 43's ability to safely self-administer her nebulizer (a device that converts liquid medication into an inhalable mist) treatment. The resident's ability to safely self-administer her inhaler was not included in that assessment.3. Interview on 3/18/26 at 1:00 p.m. with RN E revealed a physician's order was needed before a resident could self-administer a medication. RN E confirmed resident 43 had no physician's order indicating she was able to self-administer her inhaler. RN E agreed the resident should not have been handed her inhaler to self-administer.4. Interview on 3/19/26 at 9:51 a.m. with DON B revealed she did not evaluate resident 43's ability to self-administer her inhaler because she did not know the resident wanted to self-administer that medication. All residents requesting to self-administer a medication were expected to be assessed for and have a physician's order that supported their ability to safely self-administer that medication. She confirmed resident 43 was not assessed and did not have a physician's order to self-administer her inhaler.5. Review of the provider's March 2026 revised Medication: Self Administration policy revealed: B. the patient [resident] or patient's [resident's] designee for self administration must be deemed competent by the provider to perform self administration and that C. Self administration of any medication requires a provider's order for that specific medication.

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	03/19/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, interview, competency checklist review, the provider failed to follow professional standards regarding one of one certified medication aide (CMA) (F) who administered the wrong dose of medication to one of one sampled resident (24) according to their physician's order. Findings include: 1. Observation and record review on 3/18/26 at 8:35 a.m. of CMA F preparing resident 24's potassium chloride ER medication for administration revealed she compared the label on the medication's blister pack (a card with medications in individual plastic bubbles) to the physician's order listed in the resident's medication administration record (MAR) for any discrepancies. The label and MAR order matched. She then pushed one potassium chloride ER pill out of the blister pack into a medication cup. CMA F administered all resident 24's medications that she prepared. After resident 24 swallowed those medications, CMA F returned to the medication cart, opened the resident's MAR, and documented that the medication administration was completed. 2. Interview and record review on 3/18/26 at 9:00 a.m. with CMA F regarding the above medication administration revealed she confirmed she administered one potassium chloride ER pill to resident 24. She then re-read that 10/28/25 medication's physician's order which instructed to: give 2 tablet[s] by mouth one time a day . CMA F confirmed she did not administer resident 24's potassium chloride ER medication as ordered. 3. Interview on 3/19/2026 at 9:48 a.m. with director of nursing (DON) B regarding the above medication administration observation revealed that CMA F failed to administer the correct dose of potassium chloride ER medication to resident 24.Review of the provider's April 2024 Medication Administration Clinical Skills4. Checklist revealed that after certified and licensed nursing staff selected the medication to administer to a resident, they were expected to Complete the 'Rights' of medication administration including right drug, dose, route, time, and patient [resident].

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	03/19/2026

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 - Few	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** Based on observation, interview, and policy review, the provider failed to ensure resident insulin pens were labeled and discarded when they expired for two of two sampled residents' (30 and 39) whose insulin pen labels were unable to be read by the staff, and one of one sampled resident (39) who received expired insulin. Findings include:1. Observation, interview, and record review on [DATE] at 9:55 a.m. with registered nurse (RN) E revealed that inside the [NAME] Unit medication cart, a Lispro insulin pen was stored in the manufacturer's packaging box. The pharmacy label on that insulin pen was smeared, and only resident 30's first name was legible.RN E indicated it was not her usual practice to compare the insulin pen's label to the resident's medication administration record (MAR) order for any discrepancy before she administered that insulin. RN E would only refer to the insulin pen's label to verify that it belonged to the resident to whom she was administering that insulin. Continued observation of the Lispro insulin pen box with RN E revealed that the open date (the date the insulin was first opened and used) written on the insulin pen box was [DATE], and the expiration date of [DATE] was written on that box.Review of resident 30's [DATE] MAR and continued interview with RN E revealed she confirmed resident 30's Lispro insulin pen was expired. The insulin pen was to be removed from the medication cart and discarded on [DATE]. Between [DATE] and [DATE], it was documented in resident 30's MAR that he was administered insulin from that expired Lispro insulin pen five times.2. Observation and interview on [DATE] at 12:15 p.m. with RN G revealed that in the [NAME] Unit medication cart, there was a Lantus insulin pen. The pharmacy label on that pen was illegible except for resident 39's first name. RN G stated the nursing staff were expected to compare the pharmacy label on the Lantus pen to the resident's MAR order and reconcile any discrepancies between the two before that insulin was administered. RN G confirmed that expectation could not be followed because the label on that insulin pen was illegible. 3. Interview on [DATE] at 10:02 a.m. with director of nursing (DON) B regarding medication storage and labeling revealed that staff administering resident medications were expected to review medication packaging and labels for expired medication before that medication was administered.Review of the provider's revised [DATE] Medication Labels policy revealed: 7. Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the issuing pharmacy for relabeling or destroyed in accordance with facility medication policy.