

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435102		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/19/2026	
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH STURGIS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 JUNCTION AVENUE , STURGIS, South Dakota, 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			
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/17/26 through 3/19/26. Monument Health Sturgis Care Center was found not in compliance with the following requirements: F554, F658, F761, and F880.	F0000					
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: 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	F0554	F0554 Corrective Action: 1.For the identification of and lack of provider failing to follow professional standards regarding one of one registered nurse (RN) 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 sample 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, a self-administration assessment was completed for resident (43) on 3/19/26. A physician order to self-administer Trelegy Ellipta (a medication to improve lung function) inhaler (a portable device for administering a medication that is breathed into the lungs) for resident (43) was obtained on 3/19/26. Education was provided to RN E on 3/19/26 that a physician order and self-administration assessment are needed before a resident can self-administer a medication per the Medication: Self Administration policy. 2. All current and future residents are potentially affected by the deficiency of failing to ensure one of one sample resident (43) who did not have a physicians' order, or a medication self-administration assessment completed for the inhaler and was observed self-administering the medication. The facility will ensure future and current nursing staff will complete initial and annual education to ensure they are competent on providers Medication: Self Administration policy.	5/2/26			

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 reverse for further 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 President	(X6) DATE 4/12/26
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F0554 SS = D	<p>Continued from page 1 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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."</p>	F0554	<p>Medication: Self Administration 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 5/2/26, or before their next scheduled shift if unable to receive education prior to 5/2/26. Medication: Self Administration 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 5/2/26, or before their next scheduled shift if unable to receive education prior to 5/2/26. The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies/procedures for the above identified areas.</p> <p>Monitoring: An audit tool has been created to audit that nursing staff are competent with Medication: Self Administration 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. The Medication: Self Administration 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. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additionally, education opportunities will be directed by the QAPI committee in response to audit reports.</p>				
F0658 SS = D	<p>Services Provided Meet Professional Standards</p> <p>CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p>	F0658	<p>F0658</p> <p>Corrective Action: 1. For the identification of and lack of provider failing 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.</p>	5/2/26			

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F0658 SS = D	<p>Continued from page 2</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Review of the provider's April 2024 Medication Administration Clinical Skills</p> <p>4. 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]."</p>	F0658	<p>Education was provided to (CMA) (F) on 3/19/26 to verify/complete the 'rights' of medication administration including right drug, dose, route, time, and patient (resident) per the Medication Administration Clinical Skills.</p> <p>2. All current and future residents are potentially affected by the deficiency of failing 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 order. The facility will ensure future and current nursing staff will complete initial and annual education to ensure they are competent on providers Medication Administration Clinical Skills.</p> <p>Medication Administration Clinical Skills education will be tracked by the DON or designee to ensure completion.</p> <p>All identified education was provided to all specified staff, no later than 5/2/26, or before their next scheduled shift if unable to receive education prior to 5/2/26.</p> <p>The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies/procedures for the above identified areas.</p> <p>Monitoring: An audit tool has been created to audit that nursing staff are competent with Medication Administration Clinical Skills. 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.</p> <p>The Medication Administration Clinical Skills 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.</p> <p>For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additionally, education opportunities will be directed by the QAPI committee in response to audit reports.</p>	
F0761 SS = D	Label/Store Drugs and Biologicals	F0761		

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F0761 SS = D	<p>Continued from page 3 CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>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.</p> <p>Findings include:</p> <p>1. Observation, interview, and record review on 3/17/26 at 9:55 a.m. with registered nurse (RN) E revealed that inside the Massa 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.</p> <p>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.</p>	F0761	<p>F0761</p> <p>Corrective Action: 1. For the identification of and lack of provider failing to ensure resident insulin pens were clearly 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. Education provided to RN (E) on 3/19/26 to check every expiration date prior to administering a medication. If a medication label is hard to read, please contact the pharmacy to obtain a new label per providers Medication Label policy. Education provided to RN (G) on 3/19/26 that if medication label is hard to read, please contact the pharmacy to obtain a new label per provider's Medication Label policy. Prescription labeled bag was obtained from the pharmacy on 3/20/26 for resident (39) Lantus insulin pen. Resident (39) Lantus insulin pen will be stored in this prescription labeled bag to be able to compare the pharmacy label for this Lantus pen to the resident's MAR order and reconcile any discrepancies between the two before that insulin pen is administered.</p> <p>2. All current and future residents are potentially affected by the deficiency of failing to ensure resident insulin pens were clearly 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. Effective 4/10/26, the facility will ensure that prescription labeled bags are sent from the pharmacy with each insulin pen so that the prescription labels remain legible. The facility will ensure future and current nursing staff will complete initial and annual education to ensure they are competent on providers Medication Label policy. Medication Label 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 5/2/26, or before their next scheduled shift if unable to receive education prior to 5/2/26.</p>	5/2/26

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F0761 SS = D	<p>Continued from page 4</p> <p>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 2/12/26, and the expiration date of 3/11/26 was written on that box.</p> <p>Review of resident 30's March 2026 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 3/11/26. Between 3/14/26 and 3/16/26, it was documented in resident 30's MAR that he was administered insulin from that expired Lispro insulin pen five times.</p> <p>2. Observation and interview on 3/17/26 at 12:15 p.m. with RN G revealed that in the Barry 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.</p> <p>3. Interview on 3/19/26 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.</p> <p>Review of the provider's revised May 2019 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."</p>	F0761	<p>Monitoring: An audit tool has been created to audit that nursing staff are competent with Medication Label 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. The Medication Label 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. For the QAPI committee to discontinue the audit, three consecutive months of 90% compliance will have to have been achieved. Additionally, education opportunities will be directed by the QAPI committee in response to audit reports. The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies/procedures for the above identified areas.</p>	
F0880 SS = E	<p>Infection Prevention & Control</p> <p>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p>	F0880	<p>F0880 Corrective Action: 1. For the identification of and lack of provider failing to ensure resident 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).</p>	5/2/26

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F0880 SS = E	<p>Continued from page 5</p> <p>§483.80(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents</p>	F0880	<p>Education provided to (RN) (E) on 3/19/26 to understand the need for Personal Protective Equipment (PPE) perform hand hygiene before performing a blood sugar check per the Glucometer Competency Checklist. Education provided to (CMA) (F) on 3/19/36 to not have tape or any foreign objects on your hands while administering medications. Handy Hygiene policy education provided to (CMA) (F) on 4/10/26. Education provided to (RN) (E) on 3/19/26 to follow the enhanced barrier precautions posted on a resident's door while completing a dressing change per the Enhanced Barrier Precaution Sign. Hand Hygiene policy education provided to (RN) (E) on 4/10/26.</p> <p>2. All current and future residents are potentially affected by the deficiency of failing to ensure resident 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). The facility will ensure future and current nursing staff will complete initial and annual education to ensure they are competent on providers Glucometer Competency Checklist, Hand Hygiene policy, and Enhanced Barrier Precautions. Glucometer Competency Checklist, Hand Hygiene policy, and Enhanced Barrier Precaution education will be tracked by the DON or designee to ensure completion.</p> <p>All identified education was provided to all specified staff, no later than 5/2/26, or before their next scheduled shift if unable to receive education prior to 5/2/26. The administrator, DON and/or designee in consultation with the medical director has reviewed, revised, or created all educational policies/procedures for the above identified areas.</p>	

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F0880 SS = E	<p>Continued from page 6 identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and policy review, the provider failed to ensure the staff followed infection prevention and control practices regarding:</p> <p>*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).</p> <p>*Hand hygiene and no gown use by one of one RN (E) during wound care for one of one sampled resident (13).</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>RN E exited the resident's room and returned to the medication cart. She removed and discarded her gloves,</p>	F0880	<p>Monitoring:</p> <p>An audit tool has been created for each area to audit that nursing staff are competent with Glucometer Competency Checklist, Hand Hygiene policy, and Enhanced Barrier Precautions. 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.</p> <p>The Glucometer Competency Checklist, Hand Hygiene policy, and Enhanced Barrier Precautions, Audit tools 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.</p> <p>For the QAPI committee to discontinue each audit, three consecutive months of 90% compliance will have to have been achieved. Additionally, education opportunities will be directed by the QAPI committee in response to audit reports.</p>	

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(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
F0880 SS = E	<p>Continued from page 7 performed hand hygiene, then disinfected the glucometer before placing it back inside the medication cart.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	F0880		

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NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH STURGIS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 JUNCTION AVENUE , STURGIS, South Dakota, 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
F0880 SS = E	<p>Continued from page 8 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435102	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH STURGIS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 JUNCTION AVENUE , STURGIS, South Dakota, 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
F0880 SS = E	<p>Continued from page 9 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.</p> <p>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".</p> <p>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".</p>	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435102	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH STURGIS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 JUNCTION AVENUE , STURGIS, South Dakota, 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
E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 3/17/26. Monument Health Sturgis Care Center was found in compliance.	E0000		

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 reverse for further 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 Manage Plant Operations	(X6) DATE 4/13/26
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MASSA B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH STURGIS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 JUNCTION AVENUE , STURGIS, South Dakota, 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
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 3/17/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Monument Health Sturgis Care Center was found in compliance.	K0000		

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 reverse for further 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 <i>Manager Plant Operations</i>	(X6) DATE <i>4/13/26</i>
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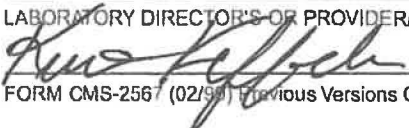
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BERRY B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH STURGIS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 JUNCTION AVENUE , STURGIS, South Dakota, 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
K0000 Bldg. 02	INITIAL COMMENTS A recertification survey was conducted on 3/17/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Monument Health Sturgis Care Center was found in compliance.	K0000		

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 reverse for further 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 <i>Manager Plant Operations</i>	(X6) DATE <i>4/13/20</i>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ADMIN B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH STURGIS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 JUNCTION AVENUE , STURGIS, South Dakota, 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
K0000 Bldg. 03	INITIAL COMMENTS A recertification survey was conducted on 3/17/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Monument Health Sturgis Care Center was found in compliance.	K0000		

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 reverse for further 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 Manager Plant Operations	(X6) DATE 4/13/26
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FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID: 1E0B8E-L1 Facility ID: 0041 If continuation sheet Page 1 of 1

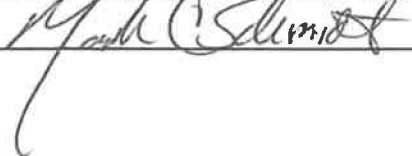
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10693	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2026
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NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH STURGIS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Compliance/noncompliance Statement</p> <p>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/17/26 through 3/19/26. Monument Health Sturgis Care Center was found not in compliance with the following requirement: S296.</p>	S 000		
S 296	<p>44:73:07:11 Director Of Dietetic Services</p> <p>A facility shall have a full-time dietary manager who is responsible to the administrator and who shall direct the dietetic services.</p> <p>The dietary manager must:</p> <ol style="list-style-type: none"> (1) Be a certified dietary manager; (2) Be a certified food service manager; (3) Have a similar national certification for food service management and safety from a national certifying body; or (4) Have an associate's or higher degree in food service management or hospitality from an accredited institution of higher learning that has a course of study in food service or restaurant management. <p>Any dietary manager who does not must enroll, within ninety days of the dietary manager's hire date, in programming necessary to achieve one of the qualifications, and achieve the qualifications within eighteen months of hire. The dietary manager and at least one cook shall possess a current certificate from a ServSafe Manager Food Protection Program offered by various retailers, the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition and Foodservice Professionals, or an equivalent training program as determined by the department. Individuals seeking ServSafe recertification are only required</p>	S 296	<p>The facility shall have a full-time dietary manager who is responsible to the administrator and who shall direct the dietetic services. The Director of Food and Nutrition (DFN) will obtain their Certified Food Manager certification by May 2, 2026.</p> <p>In the interim, the Systems Director for Monument Health provides oversight of the account until the DFN completes and graduates with their Certified Dietary Manager (CDM) credential from the University of North Dakota.</p> <p>Additionally, a full-time Registered Dietitian oversees the account, along with the Director of Clinical Dietitians, who works closely with the facility to ensure compliance and</p>	5/2/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

President

(X6) DATE

4/10/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10693	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH STURGIS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
S 296	<p>Continued From page 1</p> <p>to take the national examination.</p> <p>The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility must schedule dietitian consultations onsite at least monthly. The dietitian shall approve each menu, assess the nutritional status of each resident with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits.</p> <p>The facility shall have sufficient personnel to meet the dietetic needs of the residents and provide dietetic services for a minimum of twelve hours each day.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and policy review, the provider failed to ensure: *One of one director of food and nutrition (DFN) (C) achieved one of the required dietary manager qualifications within 18 months of hire, and that she and at least one cook were ServSafe certified.</p> <p>Findings include:</p> <p>1. Interview on 3/18/26 at 10:50 a.m. with DFN C and chef D revealed DFN C was responsible for the overall operation of the provider's food and nutrition services. Chef D reported directly to DFN C and was responsible for the kitchen staff and the operation of the kitchen.</p> <p>DFN C was in her current position for "about 2 1/2 years." She started in April 2025, but did not complete, the required dietary manager training.</p>	S 296	<p>1. Corrective action: One of one Director of Food and Nutrition (DFN) (C) achieved one of the required dietary manager qualifications within 18 months of hire, and that she and at least one cook were ServSafe certified. Corrective action put into place is before the day of 5/2/2026 both (DFN)(C) will have taken the final test and will have their ServSafe Certifications.</p> <p>2. A tracking system has been implemented in the form of a certification calendar. This calendar will:</p> <ul style="list-style-type: none"> • Monitor all food safety certification expiration dates • Provide reminders 6 months prior to expiration • Allow adequate time for scheduling renewal courses and exams <p>This system ensures proactive management of certification requirements moving forward.</p>	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10693	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2026
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NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH STURGIS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 296	<p>Continued From page 2</p> <p>DFN C indicated she and chef D completed the ServSafe Manager Food Protection Program course in "June or July 2025", but neither of them completed the testing required for that certification. There were no other cooks with that certification.</p> <p>2. Review of the March 2006 Morrison Healthcare Director of Food and Nutrition Job Description revealed: *The education and experience qualifications for the DFN position included: "Must meet CMS [Centers for Medicare and Medicaid Services] and/or state regulations regarding educational qualification for Food Service Director (e.g. Dietary Manager)." *Other Qualifications: "ServSafe certified within one (1) year of date of hire."</p>	S 296		