STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hendricks Community Hospital	503 E Lincoln Street Hendricks, MN 56136

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34083 Based on interview and document review the facility failed to notify the resident representative and/or physician for 1 of 1 resident (R48), who experienced a witnessed fall on 12/10/23. Findings include: Review of the 12/10/23 at 10:45 a.m., nursing progress note, and incident report identified R48 was combative toward an unidentified nursing assistant (U-NA) as he was assisting him to toilet and placed his soiled pants into a plastic bag for laundering. R48 had attempted to grab the bag from the NA when he fell to the floor. R48 denied injury and was seated on his bed when licensed practical nurse (LPN)-B was called to the room. He reported he wanted his pants back, when asked what had happened. LPN-B explained his pants needed to be washed and dried because they had BM on them. R48 voiced no further concerns, denied pain, his range of motion was intact, but he refused to allow vital signs to be checked x 3. There was no mention R48's physician or family had been notified of his fall. Review of the 12/10/23, Post Fall Huddle-SBAR identified R48 attempted to grab the U-NA with his soiled hands as he was placing the soiled pants into a clear plastic bag. The U-NA called for assistance due to R48 being combative due to thinking his soiled pants were being discarded when he was being toileted. R48's call light and assistive devices were noted to have been within his reach at the time of the fall. There was no mention R48's physician or family had been notified of his fall. Review of R48's 12/10/23 at 5:49 p.m. incident report failed to identify notification of either the resident's responsible party (power of attorney-POA) nor his physician. The electronic medical record also failed to contain any documentation of notification of the POA or provider for R48's fall. R48's 12/14/23 at 1:06 p.m., physician progress note identified R48 was assessed for hip pain after being notified of new onset pain that day earlier at 11:00 a.m. X-rays were ordered which showed a fracture of his right hip. The facility and family were notified. R48's family agreed with a transfer to the regional hospital for further assessment and potential surgical repair. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/30/24 at 10:00 a.m. with family member (FM)-A reported she had not been informed of R48's fall and it was not until 12/14/23 when she had come to visit and R48 reported to her, he was not able to get out of bed or lift his right leg due to lower right calf area pain. FM-A spoke with the director of nursing (DON) regarding her concerns and questioned she had not been notified and why there was a delay in medical assessment. She reported if she had been notified, she would have wanted him to be checked out (examined by a physician) right away at the time of the fall. Interview on 5/30/24 at 10:01 a.m. with the DON reported her expectation for staff to notify both the physician and family of a fall or incident within a reasonable amount of time (i.e., 1 hour or sooner). A policy for incident/accident notification of responsible parties and medical providers was requested but not provided.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 47497 Based on observation, interview, and record review, the facility failed to develop a plan to reduce or discontinue the use of a seatbelt type of restraint for 1 of 1 resident (R17). Findings include: R17's 4/9/24, significant change Minimum Data Set (MDS) assessment identified R17's cognition was severely impaired, with diagnosis of non-traumatic brain injury, Alzheimer's disease, dementia, anxiety, depression, history of falls, and delusions (misconception of beliefs that are firmly held, contrary to reality). R17 used a wheelchair, was dependent on staff for ADL's (activities of daily living), and had a trunk restraint in place. R17's current care plan identified she was at risk for falls with interventions to keep room clear from clutter, provide adequate lighting, ensure gripper socks are on, provide PT/OT as needed, provide activities such as word find puzzles when attempting to self- transfer. The care plan also had interventions of anti-lock brakes on wheelchair, and a seat belt type restraint that she was not always able to remove independently and a bed alarm at night. Staff were to toilet her every 2 hours while awake, and every 2-3 hours at night. R17's care plan also identified she was vulnerable to injury during use of a restraint related to mobility deficits and falls with injury. The care plan identified a goal to decrease or eliminate restraint usage, however, it did not identify any plan or intervention to achieve that goal. Observation on 5/28/24 at 11:16 a.m., R17 is seated in her wheelchair near the nurse's station with a seatbelt buckled across her abdomen. The buckle is black with an orange button that has to be pushed in to release the belt. Review of 1/4/24 physician order identified facility was to start lorazepam 0.5 mg 3 times daily by mouth and a seat belt type restraint while in wheelchair for anxiety and mobility deficits. Review of behavior monitoring from 4/1/24 through 5/29/24, identified R17 displayed behaviors of not wanting to stay in bed 5 times and attempted elopement 3 times, with interventions of getting R17 out of bed and into her wheelchair, bringing R17 to a safe place, and on one occasion, administering lorazepam. Documentation noted interventions were effective. R17's medical record identified she was seen on routine nursing home rounds 2/13/24. That visit had not taken place until 40 days after her restraint was initially ordered. The physician identified behaviors had significantly improved but that R17 had a gradual decline in general overall health. Nursing was very pleased that her behaviors have decreased substantially since the scheduled lorazepam. The dictation also identified R17 had a seatbelt in place that she could unlock herself and that the therapy department and nursing were monitoring weekly. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 5/29/24 at 9:32 a.m., R17 with registered nurse (RN)-C identified R17 was asked to remove her seatbelt. R17 was unable to remove it and was asked by RN-C a total of 3 times to remove her seat belt. R17 appeared confused and asked RN-C, I have a seat belt?. She felt around her abdomen area, then stated I can't. RN-C agreed R17 was unable to remove the locked seatbelt upon request. Interview on 5/29/24 at 11:00 a.m., with assistant director of nursing (ADON) stated we are not assessing the seat belt enough She identified they had not developed a plan for removal because they do not have enough staff to supervise her on a 1:1 trial basis. Interview on 5/29/24 at 11:40 a.m., with director of nursing (DON) identified they had not tried anything less restrictive and had not developed a plan for removal. She identified that the facility would start working on a plan for removal immediately. Interview on 5/30/24, at 9:48 a.m., with the administrator identified he would expect nursing to follow the facility policy, the facility should only use restraints on a short-term basis if there were no alternative and to start developing a plan for removal immediately after the restraint is in place. Review of the Use of Restraints facility policy last revised April of 2017, identified use of restraints is permitted if their use is immediately necessary to prevent the resident from injuring himself/herself or others. The emergency use of restraints must not extend beyond the immediate episode. The facility must obtain a written order from the physician that includes the specific reason for the restraint, how the restraint will be used to benefit the resident's medical symptom, the type of restraint, and period of time for the use of the restraint. Orders for restraints will not be enforced for longer than twelve hours unless the resident's condition requires continued treatment. Re-orders are issued only after a review of the resident's condition by his or her physician. The care plan shall also include the measures taken to systematically reduce or eliminate the need for restraint use.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 39988 Based on observation, interview, and document review the facility failed to ensure oxygen flow rate parameters were identified for an oxygen order, failed to deliver the supplemental oxygen according to the physician order, and revise the care plan for 1 of 1 (R3) resident reviewed. Findings include: R3's 4/13/24, quarterly Minimum Data Set (MDS) assessment identified R3's cognition was moderately impaired, she had no behaviors, she needed supervision for most cares with some assistance. R3 had no pain and was not short of breath. R3 took an antidepressant, diuretic, an antibiotic, and she did not use oxygen during the assessment period. R3's 5/29/24, printed diagnosis list identified diagnoses of dementia, anxiety, sleeping difficulty, depression, anemia, confusion, congestive heart failure, history of stroke, shortness of breath, coronary artery disease, and hypertension. R3's 5/29/24, printed care plan identified R3 had impaired respiratory status due to congestive heart failure. R3 would maintain her respiratory status with the use of oxygen as needed. R3 had current order for as need oxygen at 1 liter per minute (L) to keep her oxygen level above 90%. Staff were to check her oxygen level if she complained of shortness of breath. R3's 9/27/23, current oxygen order identified Oxygen continuous to keep oxygen level above 90%. The order had no flow rate or flow rate range identified. Review of R3's oxygen level monitoring from 4/2/24 through 5/29/24 identified that R3 did not use oxygen during that time frame, starting on 5/17/24 through 5/29/24 R3's documentation identified R3's oxygen level had been checked 20 times and she was provided oxygen at 2L for 10 of the 20 times and 1L for 7 of the 20 times. Review of the facility infection control surveillance identified that R3 had been diagnosed with influenza A on 5/15/24. Observation on 5/28/24 at 9:53 a.m., R3 was laying in bed with her nasal cannula positioned on her forehead, the oxygen concentrator flow rate was set at 1L. Observation on 5/28/24 at 12:37 p.m., R3 was laying in her bed sleeping with no oxygen on, the oxygen tubing was laying on the concentrator about 3 feet from her bed. Observation on 5/28/24 at 5:30 p.m., staff wheeled R3 into the dining room and parked her at the table. R3 had oxygen on at 1.5L via nasal cannula. Observation on 5/28/24 at 6:52 p.m., R3 was laying on her bed with her nasal cannula on, oxygen flow rate at 1.5L still attached to the portable tank on the back of her wheelchair. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 5/29/24 at 9:02 a.m., R3 was seated at the dining room table with no oxygen on. No oxygen tubing connected to the portable tank on the back of her wheelchair and the portable oxygen tank was off. Observation on 5/29/24 at 9:31 a.m., R3 was sitting in the recliner in her room, she had her oxygen on via nasal cannula at 1L from her concentrator. Interview on 5/29/24 at 11:00 a.m. with director of nursing (DON) identified R3's current order was oxygen as needed at 1L to keep oxygen level above 90% and staff were to check her oxygen level if she complained of shortness of breath. The DON then provided a copy of the order upon request which identified the order date of 9/26/22 and a review date of 7/1/23. Interview on 5/29/24 at 1:29 p.m., with assistant director of nursing (ADON) identified R3's oxygen order was for continuous oxygen to keep oxygen level above 90%. The ADON provided a copy of the order upon request which identified order date 9/27/23, oxygen frequency as continuous to keep oxygen level above 90%. There was no flow rate or flow rate range identified on the order. The ADON confirmed that there was no flow rate or range indicated and that staff were able to make their own judgement on the flow rate in order to keep R3's oxygen level above 90%. Interview on 5/29/24 at 2:28 p.m., with DON identified the nurse would receive an order and then would enter the order into the computer system. The provider reviewed medication orders during visits but the order list that the provider reviewed only contained medications and did not contain oxygen orders or treatments. The DON revealed the provider would not know what the resident's oxygen level had been running if monitored or what the current flow rate was unless the case manager documented that information for the provider to review. She agreed if the nurse did not bring that information forward for the provider to review the provider may be unaware that the resident was even on oxygen. She agreed this was concerning. When asked about R3's current order for continuous oxygen to keep oxygen level above 90% with no flow rate or range identified she confirmed that the nurse or trained medication aide would have to make that judgement call on what to set the oxygen rate at and that also was not appropriate. She was unaware that the order did not have a flow rate or range for the nursing staff to use. She confirmed that the order should have been clarified. Interview on 5/29/24 at 3:11 p.m., with trained medication aide (TMA)-A who pulled up R3's oxygen order on the computer at her medication cart and identified that R3 had an order for oxygen as needed at 1L to keep her oxygen level above 90%. She reported that the nursing staff checked R3's oxygen level every shift. She did not bring up the current oxygen order dated 9/27/23. Interview on 5/29/24 at 3:20 p.m., with licensed practical nurse (LPN)-A who pulled up R3's oxygen order on the computer at the medication cart and identified that R3 had an order for oxygen as needed at 1L to keep her oxygen level above 90%. He did not bring up the current oxygen order dated 9/27/23. Interview on 5/29/24 at 4:52 p.m., with ADON who was informed that the staff had pulled up the old order that identified oxygen as needed at 1L verses the current order of continuous oxygen to keep oxygen level above 90% stated that the DON had just obtained a new order for as needed at 1L to keep her oxygen level above 90%. She identified that the medical record was being update. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of October 2010, Oxygen Administration policy identified staff were to verify the physician's order for oxygen administration and review the resident care plan for any special needs. The policy identified unless otherwise ordered to start the oxygen flow rate at 2 to 3 liters per minute. Review of November 2014, Medication Orders policy identified oxygen orders were to contain specified rate of flow, route, and rationale.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34083 The facility's request for a waiver was accepted and approved by the State Agency following the survey dated 7/17/23. The tag was re-issued however, NO plan of correction is required. This will remain in effect until such time as the registered nurse (RN) coverage can be filled and the facility achieves compliance. F727: CFR 483.35 (b)(1), RN coverage 8 consecutive hours a day, 7 days a week. Findings include: Review of the facility nursing staff schedules for February 2024, March 2024 and April 2024 identified in: 1) February 2024, there no 8-hour consecutive RN coverage for 6 of 29 days: 2/3; 2/4; 2/10, 2/11; 2/18, and 2/25/24 2) March 2024, there was no 8-hour consecutive RN coverage for 2 of 31 days: 3/3 and 3/17/24. 3) April 2024, there was no 8-hour consecutive RN coverage for 2 of 30 days: 4/14 and 4/28/24. Interview on 5/28/24 at 12:41 p.m. with licensed practical nurse (LPN)- B (staff scheduler), reported she completed assignments and notified management of call-ins. She reported when there was a call-in, she communicated the open shift via text message and updated the administration team. Interview on 5/29/24 at 12:16 p.m. with the administrator reported he had reached out to many resources in addition to utilizing online websites to obtain licensed employees. Interview on 5/29/24 at 12:21 p.m. with human resources (HR) identified she had posted staff openings on Indeed, the facility website, Handshake (for college students), and Lake area tech. She reported she had not had much luck with responses. She reported the facility had attempted one local job fair in [NAME] and had been involved with job fairs held with South Dakota state university. She reported most to the applications had been a result of Indeed or the website and when she received an application, she immediately contacted the applicant to set up an interview with the facility. Interview on 5/30/24 at 10:30 a.m. with the director of nursing (DON) reported the facility continued to struggle with consecutive registered nurse (RN) 8 hour/24-hour coverage, but the facility was attempting to find more staff but at the present time needed to continue with the RN waiver. Review of the July 2023, Scheduling and Absenteeism Policy -HCHA Long Term Care identified the facility policy was to maintain staff staffing levels and provide the necessary care and safety to the residents in the facility, Staffing was identified according to need with the number of residents residing in the facility. The policy identified the goal of RN coverage a minimum of 8 hours/24 hours, 7 days/week.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47497 Based on interview and record review the facility failed to ensure 1 of 5 resident (R33) had a qualifying diagnosis for routine use of an antipsychotic. Findings include: R33's 4/13/24, quarterly Minimum Data Set (MDS) identified R33 had moderate difficulty hearing, uses a hearing aid, speaks clearly, she can make her needs known, and usually understands others. R33's cognition was moderately impaired, she required extensive assist from staff for transfers, dressing, and hygiene. She had diagnosis of depression and dementia. R33 was being administered an antipsychotic on a routine basis and had other behavior symptoms not directed toward others on 4 to 6 days during the look back period. R33's current physician orders identified she was receiving Lexapro 10 milligrams (mg) (antidepressant) daily for depression and risperidone 0.5 mg (antipsychotic) daily at bedtime for agitation. R33's 4/29/24 through 5/29/24, behavior monitoring identified R33 had behaviors of calling out for help, not using call light for help, requesting to use the bathroom every 15 minutes, yelling into the hallway for help to the bathroom and yelling for help when staff were in the room. Staff provided interventions were to re-educate resident to use call light, offer food, water, and/or toileting. R33's current care plan identified she had behaviors of yelling out for staff and not using call light related to dementia with interventions for staff to ask R33 if she had pain or discomfort and to instruct her to use her call light as she is cognitive and remind her that it is not necessary to yell. Staff were to answer call light promptly as yelling may be from feeling the urge to toilet related to cancer history. R33's medical record lacked any indication that a root cause analysis had been completed to determine the cause of her behaviors of yelling out and frequent urges to urinate. Interview on 5/29/24, at 4:31 p.m., with director of nursing (DON) identified she agreed that R33 did not have an appropriate diagnosis for the use of an antipsychotic medication. She identified the reason for the antipsychotic medication was for her behaviors of yelling out for assistance and toileting or if she is unable to sleep at night. She identified staff are to reminder to use her call light. Interview on 5/30/24 at 9:48 a.m., with the administrator identified he would expect staff to follow the policy for antipsychotic use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the December 2016, facility Antipsychotic Medication Use policy identified antipsychotic medications shall generally be used only for conditions/diagnoses as documented in the record and consistent with the definitions in the Diagnostic and Statistical Manual of Mental Disorders: schizophrenia, schizo-affective disorder, schizophrenia disorder, delusional disorder, mood disorders (e.g. bipolar disorder, depression with psychotic features, and treatment refractory major depression), psychosis in the absence of dementia, medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania, Tourette disorder, Huntington's disease, hiccups, or nausea and vomiting associated with cancer chemotherapy.

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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. 49336 Based on observation, interview and document review, the facility failed to ensure 1 of 2 E-kits (emergency kit) did not have expired medication and maintain their system for disposition of controlled and/or narcotic substances to immediately detect and reconcile to prevent drug diversion. Findings include: Observation, interview, and document review on 5/28/24 at 10:48 a.m., with registered nurse (RN)-D of the facility's large emergency kit (E-kit) located in medication room had an attached unsigned inventory list that identified for Lorazepam 0.5 mg (milligrams), Hydrocodone/APAP 5/325 mg and Tramadol 100 mg tablets with an expiration date of 5/16/24 on the inventory list. The large e-kit had a plastic lock with the number 12772528 that contained 8 tablets of hydrocodone in a bubble pack with the expiration date of 5/16/24, 11 tablets of tramadol in a bubble pack with the expiration date of 5/16/24, and 2 tablets of Lorazepam in a bubble pack with expiration date of 5/16/24. RN-D stated nurses were to complete e-kit tag verification each shift and the local pharmacy would check the e-kit monthly and was responsible to remove expired medications in the e-kit. She stated the inventory log was provided from the pharmacy and would include a list of controlled medications that are accessible for nurses to use for emergent needs. Observation, interview, and record review on 5/28/24 at 1:34 p.m., with pharmacist (RPh) stated the tramadol, hydrocodone and lorazepam bubble packs were expired and was not replaced. He stated the facility E-kit controlled medications were not checked monthly by pharmacy. The RPh was to receive notification from nursing staff of expired controlled substances for refills, but that had not been completed. He agreed the facility needed to ensure no expired medications remained in the e-kit. Interview on 05/28/24 02:55 PM with director of nursing (DON) identified her expectation would be for the pharmacy to check e-kit medication monthly and to ensure controlled substances are recorded on the log by nursing staff with each shift for verification and were accounted for and accurate as stated in the facility policy. Review of 12/2023 LTC Emergency Medication Kit policy identified medications will be reviewed by pharmacy and they were to complete an audit monthly to verify counts and expiration dates.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49336 Based on interview and document review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify facility specific concerns, implement an action plan to correct the identified concerns or to ensure the committee participated in the development and oversight of implementation of systems, and to ensure quality of life and quality of care were maintained for 46 residents residing in the facility. Findings include: Review of undated, facility performance improvement plan (PIP) identified a goal for the facility to observe medication administrations in the facility's dining room. The action plan was for education to be provided for nurses and train medication aides (TMA's) on medication administration. The improvement plan had no mention of a target date nor observation dates or times of medication administrations observed. The plan lacked interventions that would analyze the underlying cause and opportunities for improvement. Interview on 5/29/24 at 3:52 p.m., with director of nursing (DON) stated the nursing home utilized an online quality scorecard for both the hospital and nursing home that would track PIP's in the facility. She stated the facility would implement quality improvements projects during the fiscal year for month of July 2023 to June 2024. She stated the facility had no PIP's from the month of July 2023 to March 2024. She stated she had encouraged the administration and department heads during the facility monthly meetings to identify areas of improvement that facility could work on and create a PIP on the online quality scorecard. She stated she was aware that a PIP plan had recently been added on the facility scorecard by a department head who identified an improvement for medication administration. She stated the had been posted on SharePoint in the month of April of this year, because the facility had no success in implementing a PIP the last few months. She stated the current PIP needed improvements and stated it lacked audits and consistent data for analyzing performance improvements. Review of the February 2024, QAPI policy identified the QAPI program was to develop and implement performance improvement activities.

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	245467	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hendricks Community Hospital	503 E Lincoln Street Hendricks, MN 56136

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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 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a Compliance and Ethics Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336 The facility failed to ensure the development and implementation, and the maintainence of an effective compliance and ethics program for oversight when 1 of 1 employee registered nurse (RN)-D, advised licensed practical nurse (LPN)-E to sign-off on a narcotic documentation form as having witnessed the count, when in fact, they had not. Findings include: Review of the facility west wing Shift Verification of Controlled Substances Count form identified one entry of a nurse signature missed on 5/16/24 for the 6:00 a.m. shift and a second entry of a nurse signature missed on 5/28/24 for the 10:00 p.m. to 6:00 a.m. shift. The documentation lacked supporting evidence to verify if the narcotic counts were completed appropriately. Observation and interview on 5/28/24 at 6:37 p.m., with LPN-E stated he was unaware of who completed the narcotic count with him and was aware the narcotic count was completed before his shift on 5/16/24 and confirmed the form was not sign by the departing nurse. Observation and interview on 5/28/24 at 6:39 p.m., with RN-D stated she worked the morning of 5/28/24 and stated LPN-C and LPN-F had completed a narcotic count during the previous shift change and stated LPN-C forgot to sign her name on the form. RN-D stated she observed the two nurses count the narcotics that morning and was sure the narcotic count was completed and stated the missing signature needed to be signed. RN-D then directed LPN-E (who did not perform the count) to sign the form for the date of 5/28/24. LPN-E asked RN-D where his signature should be placed. RN-D pointed to the form for the date of 5/28/24 and advised LPN-E to sign his name. LPN-E placed his pen on the narcotic form and was stopped by the surveyor as LPN-E had not witnessed the count. Review of LPN-E timesheet identified he worked on 5/28/24 beginning at 1:52 p.m. Review of RN-D timesheet identified she worked on 5/28/24 beginning at 5:54 am to 12:45 p.m. and then again from 1:41 p.m. to 6:54 p.m Interview on 5/28/24 at 6:52 p.m., with director of nursing (DON) stated her expectations would be for the nurses and trained medication aide (TMA) to count narcotics every shift and sign the narcotic form accurately when the task was completed. Interview on 5/29/24 at 8:58 a.m., with administrator stated it is not an acceptable practice for staff to [NAME] documentation if it was not completed accurately. It was his expectation would be for all staff to complete documentation in a timely manner when the task or work had been completed. In addition, he stated his expectation would be for employees to not alter documentation, but provide a rationale for not completing documentation in a timely manner. Review of 2/16/24 Skilled Nursing Facilities Orientation Checklist for Direct Care Staff-Nursing assistants and Nurses identified QAPI, Compliance and Ethics training deadline was due upon hire. (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and record review on 5/29/24 at 10:15 a.m., with DON stated RN-D had a hire date of 2/29/20. She stated the information sent by human resources (HR) noted RN-D lacked documentation of ethics training upon hire. Review of RN-D facility education identified a printed Scorecard: All Competencies dated November, 2023 that listed completion of Ethics training. Interview on 5/29/24 at 3:14 p.m., with administrator stated the facility had no active Ethics committee but had assigned people that would meet, if requested. The facility committee had no meetings scheduled and had no reasons or concerns to meet regularly. Interview on 5/29/24 at 3:23 p.m., with DON stated she unaware of a ethics committee at the facility and had no knowledge of an ethics committee meeting regularly. Review of February, 2024 Controlled Substance Storage and Disposal policy identified controlled substance count verification should be done every shift by two (2) nurses or medication aides; one from previous shift and one form oncoming shift. Nurse and/or TMA going off duty and a nurse and/or TMA coming on duty would provide their signature. The signature would indicate the medications had been checked and the count was verified to be correct. If the narcotic count was incorrect, staff would notify the DON. Review of June, 2023 Employee Code of Conduct and Confidentiality policy identified employees will be expected to adhere to the regulations. The policy identified employees would complete medical records accurately and are expected to conduct themselves in a moral, honest and courteous manner. Review of August 2023 Ethics Committee policy identified the committee is a advisory resource for end of life situations and available as an advisory group and did not meet regularly, but would be available upon request.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 49336 Based on interview and document review, the facility failed to provide mandatory training on 1 of 1 facility specific Quality Assurance Performance Improvement (QAPI) Program to include goals and various elements of the program, how the facility intends to implement the program, staff's role in the facility's QAPI program, or how to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program. This had the ability to affect all 46 residents. Findings include: Interview on 5/29/24 at 8:28 a.m., with licensed practical nurse (LPN)-D stated she had attended one QAPI meeting in the past and was aware the facility had scheduled meetings monthly. She stated each department head attended the QAPI meetings and would discuss each departments concerns. She stated she along with another employee were working on a performance improvement project for repositioning residents in the facility to prevent pressure ulcers. She was unaware of how long the performance improvement project (PIP) would take and was unaware of long term goals from the PIP. Interview on 5/29/24 at 8:32 a.m., with LPN-C stated she had not attended any QAPI meetings and received training online (generalized online QAPI training). She stated she was unsure of what specific QAPI projects the facility had in place. Interview on 5/29/24 at 8:35 a.m., with LPN-A stated he had not attended the QAPI meeting but read the notes from the meeting that were located near the nursing station. He stated the facility had hired new staff and the facility had informed all staff of standard infection control practices and confidentiality. He stated he was unaware of anything specific the QAPI committee was working on at the facility. Interview on 5/29/24 at 8:36 a.m., with nursing assistant (NA)-C stated she had not attended any QAPI meetings and was not aware of QAPI since she started working here in the facility recently. She stated she was not aware of any specific PIP the facility had in place. Interview on 5/29/24 at 12:08 p.m., with housekeeping aide (HK)-A stated the facility had QAPI meetings and she had not attend a meeting. She stated she received updates from the QAPI meeting from her supervisor. She stated her supervisor would conduct department meetings and would go over information discussed at the monthly QAPI meetings. Interview on 5/29/24 at 4:20 p.m., with trained medication aide (TMA)-A stated she was not aware of the facility QAPI meetings and was unsure of what the facility had discussed at the QAPI meetings. The overall QAPI training was provided on EduCare an on-line course titled QAPI, Compliance and Ethics. There was no evidence to support the training was facility specific on what the QAPI committee had identified as areas for improvement, what action plans were in place or what was being monitored. (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/29/24 at 3:59 p.m., with director of nursing (DON) stated that staff were newly introduced to the implementation of QAPI meetings and training. She stated the employees were assigned online QAPI training at hire and were given the online training during their orientation. She stated the employees were not educated thoroughly on the requirements of the QAPI program and had not communicated appropriately for staff to understand the reasons for QAPI. She stated the staff needed to be trained on how to communicate their concerns and her expectation would be for staff to attend future QAPI meetings, so staff would understand the QAPI program and goals that would improve residents quality of care.