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	04/30/2025

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and document review the facility failed to ensure timely submission of a Death in facility Minimum Data Set (MDS) for 1 of 14 residents (R9) who was reviewed for an MDS record over 120 days old. Findings include: R9's medical record identified her last scheduled Minimum Data Set (MDS) assessment that had been submitted and validated was 11/26/24. R9's death in facility MDS was signed by the responsible party on 1/7/25 and locked on 1/7/25. The death in facility MDS had not been successfully submitted and/or transmitted; as R9's electronic health record identified it had been completed rather than accepted under the status section, indicating it had not been submitted. Observation, and interview and validation report review on 4/29/25 at 8:49 a.m., with registered nurse (RN)-A identified she had taken over as the MDS coordinator the second or third week of January 2025. Before that, multiple persons had completed MDS assessments. RN-A identified the person who had completed R9's final assessment completed and locked the assessment on 1/7/25, but failed to validate the assessment which would have sent the assessment to the submission file in the Meditech electronic medical record program. She kept a list of MDS due dates, and her process was to submit completed MDS's each week and review the Validation report to ensure all MDS assessments had been submitted successfully. RN-A reported she had not reviewed MDS submissions prior to her taking over the position and had not been aware of the outstanding assessment. RN-A was unsure why R9's death in facility MDS had not been validated and submitted, but she identified she would now validate and submit the assessment. Interview on 4/30/25 at 2:30 p.m. with the director of nursing (DON), identified her expectation for the MDS coordinator to keep track of Assessment Reference Date (ARD), with completion, validation, and submission of MDS assessments within the required time frames. Review of the September 2023, Completion of Assessments policy identified assessments were to be completed according to the MDS ARD with submission according to required time frames. All MDS assessments were to be completed by responsible departments prior to the last identified date of the observation period. The RN MDS coordinator completed and signed the assessment on the Assessment Reference Date.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the care plan was updated for 1 of 1 resident (R34) reviewed for side effect monitoring of anticoagulant (blood thinner) therapy. Findings include: R34's annual Minimum Data Set (MDS) dated [DATE], indicated R34 had severe cognitive impairment, received antipsychotic, antianxiety, antidepressant, and anticoagulant medication. R34's diagnoses included history of stroke and deep venous thrombosis (DVT), depression, anxiety, dementia and Alzheimer's disease. R34's medication order form printed 4/30/25, indicated R34's active order dated 4/1/25, for Eliquis (anticoagulant) 2.5 mg orally twice a day for DVT of left lower extremity (LLE). The order did not include any label comments or special instructions. R34's care plan printed 4/30/25, identified R34 was at high risk for falls as evidenced by history of multiple falls and vision loss and was at risk for medication side effects related to the use of antipsychotic, antidepressant, and antianxiety medications. R34's care plan lacked evidence of anticoagulant use, increased risk for bleeding, or need for anticoagulant side effect monitoring. During interview on 4/30/25 at 9:21 a.m., licensed practical nurse (LPN)-A confirmed R34's EMAR listed Eliquis but lacked any special instructions for monitoring for potential side effects. LPN-A further stated such instructions could also be found in the resident's care plan and confirmed R34's care plan lacked any reference to anticoagulant use, side effect monitoring or increased risk for bleeding. During interview on 4/30/25 at 10:20 a.m., director of nursing (DON) stated side effect monitoring for medications should be care planned. DON stated R34's care plan should include anticoagulant use and instruct staff to monitor for potential side effects including increased bleeding risk. DON further stated EMAR could also include special instructions for medications. DON confirmed R34's care plan and EMAR lacked any reference to anticoagulant use, risks or side effect monitoring. DON stated the MDS nurse often updated the resident's care plans and may have additional information. During interview on 4/30/25 at 10:35 a.m., MDS nurse stated side effect monitoring should be on a resident's care plan when they were receiving an anticoagulant. MDS nurse stated staff should be instructed to watch for bleeding. During interview on 4/30/25 at 10:54 a.m., consultant pharmacist (CP) stated staff should be aware of potential side effects of medications and should actively monitor for them. CP further stated this facility's population often received additional medications that put them at risk for falls and therefore, side effect monitoring of anticoagulants was particularly important. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy Anticoagulation-Clinical Protocol dated 2018, instructed staff to, Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. The policy instructed staff to monitor for possible complications such as excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other bleeding and to contact provider before administering next dose of anticoagulant. Facility policy Care Plans/Care Conferences dated 12/2022, indicated, An individualized, comprehensive plan of care will be developed, maintained and followed for each resident. The policy further indicated resident care plans should include information regarding how medications were being used and evaluated and should be updated as needed.

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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. 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 was 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 2025, March 2025 and April 2025 identified in: 1) March 2025, No 8-hour consecutive RN coverage for 2 of 31 days: 3/8 and 3/9/2025. 2) April 2025, No 8-hour consecutive RN coverage for 1 of 30 days: for 4/12/2025. Interview on 4/30/25, 2:30 p.m. with the director of nursing (DON) reported the scheduler attempted to fill open shifts and notified management of call-ins or unfilled shifts. The DON reported there was a registered nurse on call, and she could be assigned to cover the open shift also if needed, or the nurse managers could pick up and work the open hours. The facility continues to struggle with hiring to ensure there was a registered nurse (RN) 8 hour/24-hour on duty, but the facility was attempting to find more staff. Interview on 4/30/25 at 3;30 p.m., with the administrator reported the facility has reached out to many resources to fill RN positions, in addition to utilizing online web-sites to obtain licensed employees. They struggle with hiring and filling that position all days. Interview and source verification review on 4/30/25 at 3:42 p.m. with human resources officer (HR) identified she had posted staff openings on Indeed, both local and neighboring city newspapers, Facebook, and other county specific web-sites. 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure side effect monitoring for 1 of 1 resident (R34) reviewed for anticoagulant (blood thinner) therapy. Findings include: R34's annual Minimum Data Set (MDS) dated [DATE], indicated R34 had severe cognitive impairment, received antipsychotic, antianxiety, antidepressant, and anticoagulant medication. R34's diagnoses included history of stroke and deep venous thrombosis (DVT), depression, anxiety, dementia and Alzheimer's disease. R34's medication order form printed 4/30/25, indicated R34's active order dated 4/1/25, for Eliquis (anticoagulant) 2.5 mg orally twice a day for DVT of left lower extremity (LLE). The order did not include any label comments or special instructions. R34's care plan printed 4/30/25, identified R34 was at high risk for falls as evidenced by history of multiple falls and vision loss and was at risk for medication side effects related to the use of antipsychotic, antidepressant, and antianxiety medications. R34's care plan lacked evidence of anticoagulant use, increased risk for bleeding, or need for anticoagulant side effect monitoring. During interview on 4/30/25 at 7:46 a.m., licensed practical nurse (LPN)-A stated instructions such as monitoring for side effects of medications should be listed in the electronic medication administration record (EMAR) under special instructions. LPN-A stated increased bleeding was a potential side effect of anticoagulant use. During follow up interview on 4/30/25 at 9:21 a.m., LPN-A confirmed R34's EMAR listed Eliquis but lacked any special instructions for monitoring for potential side effects. LPN-A further stated such instructions could also be found in the resident's care plan and confirmed R34's care plan lacked any reference to anticoagulant use, side effect monitoring or increased risk for bleeding. LPN-A further confirmed R34's Eliquis pill bubble pack contained a yellow label instructing staff to contact provider if bleeding concerns and stated does not reference that label since those label instructions were supposed to be included in the EMAR under special instructions. During interview on 4/30/25 at 10:20 a.m., director of nursing (DON) stated side effect monitoring for medications should be care planned. DON stated R34's care plan should include anticoagulant use and instruct staff to monitor for potential side effects including increased bleeding risk. DON further stated EMAR could also include special instructions for medications. DON confirmed R34's care plan and EMAR lacked any reference to anticoagulant use, risks or side effect monitoring. DON stated the MDS nurse often updated the resident's care plans and may have additional information. During interview on 4/30/25 at 10:35 a.m., MDS nurse stated side effect monitoring should be on a resident's care plan when they were receiving an anticoagulant. MDA nurse stated staff should be instructed to watch for bleeding. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/30/25 at 10:54 a.m., consultant pharmacist (CP) stated staff should be aware of potential side effects of medications and should actively monitor for them. CP further stated this facility's population often received additional medications that put them at risk for falls and therefore, side effect monitoring of anticoagulants was particularly important. Facility policy Anticoagulation-Clinical Protocol dated 2018, instructed staff to, Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. The policy instructed staff to monitor for possible complications such as excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other bleeding and to contact provider before administering next dose of anticoagulant.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure data submitted to 1 of 1 Quality Assurance Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 47 residents. Findings include: Review of QAPI meeting minutes provided from 4/16/2024 through March 31, 2025 identified in: 1.) April 16, 2024- agenda items identified problem with falls, but no identified goal, action plan, data collection or analysis of the information identified. 2.) June 25, 2024- agenda items identified some areas of concern, but failed to include goals, action plan, method for data collection or analysis 3.) July 30, 2024- Identified working on family notification for therapy, completion of 72 H forms, resident toileting, or repositioning. No goals, action plan, data or analysis identified. 4.) [DATE]- no review of any projects in place [DATE]. 2025-no review of any projects, or associated data. 5.) January 28. 2025-no review of any projects or associated data. 6.) February 25, 2025-no review of any projects or associated data 7.) March 31, 2025-no review of any projects, however notation of team review of quality indicators and identified two areas, behaviors/antipsychotic medication use and falls. No goals, action plan, data collection or analysis included. Interview on 4/30/25 at 4:01 p.m., with the Director of Aging Services (QAPI director on the phone), and the facility administrator and the director of nursing (DON) in attendance reported the facility had not completed a thorough analysis of data to include measurable goals, plans, or outcomes. Review of the February 2024 Quality Assurance and Performance Improvement (QAPI) policy identified the facility was to have a QAPI plan to address resident's Quality of Life, and resident choices. The plan was to be developed according to details included in the Facility Assessment. The policy identified the QAPI program was to identify areas of high risk, high volume, and/or problem areas for improvement by identifying and correcting the areas of deficiency. The components to be included: 1.) Tracking and measure of performance 2.) Establish goals with thresholds for performance improvement. 3.) Identify and prioritize areas of quality deficiencies. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4.) Analyze causes of deficiencies. 5.) Develop and implement corrective action plans. 6.) Monitor and evaluate the action plan with revisions, as necessary.

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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. Based on interview and document review, the facility failed to have evidence of a Performance Improvement Project (PIP) which focused on high risk or problem-prone areas were identified with appropriate data collection, analysis, and evaluation of the identified concern(s) during Quality Assurance Program Improvement (QAPI). This had the potential to affect all 47 residents residing in the facility. Findings include: Review of QAPI meeting minutes provided from 4/16/2024 through 3/31/25, identified no PIP projects identified with Goals, Action Plans, Data collection, and Analysis for identified areas/issues of concern for improvement within the facility. Interview on 4/30/25 at 4:01 p.m., with the Director of Aging Services (QAPI director on the phone), and the facility administrator and the director of nursing (DON) in attendance reported the facility had some previous PIP projects but had not developed formal PIP plans for the past year. Review of the February 2024 Quality Assurance and Performance Improvement (QAPI) policy identified the facility was to have a QAPI plan to address resident's Quality of Life, and resident choices. The plan was to be developed according to details included in the Facility Assessment. The policy identified the QAPI program was to identify areas of high risk, high volume, and/or problem areas for improvement by identifying and correcting the areas of deficiency.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview, and document review the Quality Assurance and Performance Improvement (QAPI) committee failed to document attendance, ensure they received regular reports from the infection preventionist (IP) on the infection control program, and review State Agency (SA) and incident reports for 4 of 4 quarters reviewed. Findings include: Review of provided QAPI meeting minutes of March 31, 2024, April 16, 2024, June 25, 2024, July 30, 2024, October 23, 2024, January 28, 2025, February 25, 2025, and March 31, 2025, identified no data was correlated and presented by the IP on facility process, outcome surveillance, outbreaks, and implementation of any control measures, staff illness,and the Antibiotic Stewardship Program (ASP) related to antibiotic use and resistance data. There was no mention of any review of submitted SA or incident reports provided for review by the QAPI committee. The minutes contained a typed list of members of the QAPI committee, but there was no identification of who was absent and/or who was in attendance to confirm required attendance of the committee members at the quarterly meetings. Interview on 4/30/25 at 4:01 p.m. with the QAPI/ Director of Aging Services (via phone) and the administrator and director of nursing (DON) in attendance identified the facility did not have sign in sheets to document attendance at meetings. The QAPI director reported she recalled the IP was not present at the March 2025 meeting, but did not recall other meetings. She reported the IP gave a verbal update on what she is working on, any training provided, any concerns but did not document any areas of discussion, goals, or plan for improvement. The administrator and QAPI director reported a short version of SA and incident reports were discussed at the monthly meeting, but she was uncertain if it was discussed with the medical director quarterly. She confirmed there was no documentation of review of incident or SA reports. Review of the February 2024 Quality Assurance and Performance Improvement (QAPI) policy identified the facility was to maintain documentation to confirm the implementation of QAPI program compliance with Centers for Medicare and Medicaid Services (CMS) requirements. The QAPI committee was to consist of at a minimum, the DON, the medical director or designee, the IP, and at least three other staff, one of whom must be the facility administrator, owner, board member, or other individual with knowledge and ability to make changes in facility systems. The facility was to develop, implement and maintain a QAPI program that was effective, data driven, comprehensive and focused on provision of care regarding resident Quality of Life.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based interview and document review the facility failed to have a thorough ongoing infection control surveillance program that included resolution of symptoms and/or if any precautions had been implemented for 3 of 3 residents (R8, R12, R34). The facility also failed to identify when employees would be able to return to work after illness, dependent upon their symptoms of illness for 2 of 3 staff reviewed (nursing assistant (NA)-A, and trained medication aide (TMA)-A). Additionally, the facility failed to complete a tuberculosis screening for 1 of 5 residents (R32) reviewed. Findings include: Resident Surveillance Review of February 2025, LTC Respiratory Surveillance Line List identified the form included areas to document; Name/age/gender, Resident/staff, Hall/room, Symptoms onset date, Fever, Cough, Myalgia (body ache), Additional symptoms, Chest X-ray, Type of specimen collected/date of collection, Type of test ordered, Pathogen and Symptom resolution date. What the form lacked was if any precaution were implemented, what type of precaution, and/or when precautions were ended. Review of the 3 residents listed on the form identified: 1) R8 was identified with symptoms on 2/6/25, of fever, cough, myalgia and shortness of breath and Influenza A was identified. There was no resolution date or identification if any precautions implemented. 2) R12 was identified with symptoms on 2/6/25, of fever, cough, myalgia, and Influenza B was identified. There was no resolution date or identification if any precautions implemented. 3) R34 was identified with symptoms on 2/6/25, of fever and Influenza B was identified. There was no resolution date or identification if any precautions implemented. R8's 2/6/25, progress notes identified an encounter form had been sent to clinic related to R8 complaining of chest pain with coughing. New medication orders were received for as needed DuoNeb's and cough medication. There was no indication of any precautions being implemented. R8's 2/7/25, progress note identified that R8 had worked with therapy and after breakfast had increased respirations, elevated blood pressure and oxygen saturation was at 89% on room air. An as needed nebulizer and Mucinex was given without much improvement. Resident continued with coughing, wheezing and had crackles auscultated throughout bilateral lungs. A Call was placed to the provider and the resident was sent to ER for evaluation. Resident returned with order for Tamiflu and to continue oxygen. There was no indication of any precautions implemented. Review of progress notes for 2/8/25, 2/10/25, 2/11/25 had no mention of any type of precautions that may have been implemented. On 2/12/25, the progress note identified R8 was on quarantine for influenza and continued with a harsh cough. There was no indication when R8 had been placed in quarantine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's 2/3/25, progress note identified R12 had been coughing and the daughter had requested cough medication. There was no indication of any precaution being implemented. On 2/5/25, daughter requested a COVID test which was completed and negative. There was no indication of any precautions being implemented. The 2/6/25, progress note identified the son had requested R12 be tested for influenza. Progress notes on 2/7/25, identified a fever of 100.6, on 2/8/25 a fever of 99.4, 2/9/25 coughing, all with no indication of any precautions implemented. On 2/11/25, the progress note identified she remained in her room per protocol. There was no indication when R12 had started to remain in her room. R34's 2/6/25, progress note identified R34 had a cough, vitals taken, COVID test completed and negative. There was no indication if any precautions had been implemented or not. The 2/7/25, progress note identified R34's family was updated on the influenza diagnosis and status. R34 had a temperature of 101.3 at 10:30 p.m., and at 1:20 a.m., was down to 99.9. The was no indication if any precautions had been implemented or not. Review of progress notes on 2/8/25, 2/10/25, 2/11/25 had no mention of any type of precautions that may have been implemented. On 2/12/25, the progress note identified R34 was on quarantine for influenza and continued to cough. There is no indication when R34 had been placed in quarantine. EMPLOYEE SURVEILLANCE Review of staff call in log for January 2025 through April 2025 identified the form included area to document; Date/time, shift to be worked, name of employee, reason for call in (describe symptoms), replacement found, illness form filled out and placed in schedule, doctor note, initials of person taking call. Review of 2 staff listed on the form identified: 1) TMA-A called in on 3/3/25, with symptoms of vomiting, diarrhea, and fever. The form identified that an illness form had been filled out. Review of the Employee Illness Report form identified diagnosis/symptoms as gastroenteritis (vomiting/diarrhea) with a temperature of 100.4, date of absence was 3/3/25 and date returned to work was 3/4/25. 2) NA-A called in on 4/14/25, with symptoms of vomiting and diarrhea. The form identified that an illness form had been filled out. The director of nursing (DON) reported she was unable to find an Employee Illness Report form for NA-A. She confirmed that NA-A had returned to work on 4/15/25. Interview on 4/30/25 at 2:08 p.m., with DON agreed that the resident surveillance had not been filled out completely with no resolution date. She agreed that there was no place to identified if precaution had been implemented or not. If a resident was placed on precaution that would have been identified in the resident's progress note. She agreed it would be difficult to complete a quick audit or oversight to ensure implementation of precautions timely if not identified on the surveillance form. She confirmed that staff should not be returning to work after 24 hours of having vomiting and diarrhea and the facility should have a better follow up prior to returning to work. Review of September 2024, Infection Prevention and Control Program identified surveillance would be maintained for evaluation of effectiveness in reducing the risk of infections. Infection control program was responsible for prevention of infections through precautions, employee health program, and surveillance. The policy identified employee health surveillance for absence, the staff must complete an Employee Illness Form and staff must be cleared by a licensed nurse before returning to work. (continued on next page)

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	04/30/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of undated, [NAME] Community Hospital Association Return to Work Guidelines identified staff with diarrhea would be restricted from patient contact, environment, and food handling until symptoms resolve. Tuberculosis (TB) R32's medical record identified R32 did not have a TB baseline symptom screening completed. R32 had been administered a tuberculin skin test upon admission however, the results were never read. A second tuberculin skin test was administered on 12/25/23 and read on 12/27/23 with a negative result. Interview on 4/29/25 at 11:05 a.m., with director of nursing (DON) confirmed the TB skin test had been administered but never read. She further agreed that the TB symptom screening should have been completed prior to administering the TB skin test. She reported she already was working on re-training on TB screening and testing. Review of undated, Tuberculosis, Screening Residents for policy identified upon admission all residents would be screened for tuberculosis infection (TB). If a potential resident has been exposed or is at increased risk of TB according to the screening and TB skin test would be completed.