| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245467 | A. Building<br>B. Wing | 06/25/2026 |

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

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>Based on interview and document review, the facility failed to ensure the Resident Council's concerns during 3 of 3 months of minutes reviewed (March, April, and May 2026) were addressed with potential or actual resolution and/or responses brought back to the resident council for discussion and documented in the Resident Council minutes. Findings include: Resident council meeting was held on 6/24/26 at 2:35 p.m., with R4, R10, R22, and R34. During the meeting the residents identified they had concerns regarding the menu options and the tenderness of the meat served, especially the roast beef. They expressed having difficulty chewing the meat that was served and said they had requested other items be added to the menu, such as chili. They have requested the dietary manager (DM) attend resident council so they could express their concerns directly, however, she had not attended. They stated they have no way to know if the DM knew what their concerns were. They identified no staff had communicated with them what was going to be done to address their concerns. These requests had been vocalized in resident council to the Activity Director (AD) on multiple occasions over the past several months. They had voted for the AD to be the staff person that would represent the resident council at the facility; however, they were not certain if their concerns had been relayed to the DM. Review of resident council minutes identified in:March 2026, Resident Council minutes under the dietary old business identified residents discussed their love of meals and snacks and some of their favorite food items. Dietary new business noted resident's favorite dishes for traditional Easter meals with requests for grilled lunches through summer months and incorporating more fruits into snacks. The Resident Council minutes made no mention of the concerns with the menu plan, or tough difficult to chew meat, or that the Resident Council would like the DM to attend a council meeting. April 2026, Resident Council minutes under dietary old business identified residents discussed their favorite dishes for traditional Easter meals. They requested grilled lunches through summer months and incorporating more fruits into snacks. New business identified they discussed Muffins and Moms event and that residents had no feedback regarding their meals or snacks for the month. The Resident Council Minutes made no mention that residents wanted the DM to attend a meeting or that they had concerns with the menu plan or tough difficult to chew meat. May 2026 Resident Council minutes under dietary old business identified they discussed Muffins and Moms event and that residents had no feedback on their meals or snacks for the month. Under new business the minutes noted residents enjoyed taco in a bag in May and would like to have it again in June. They discussed having fresh fruits, breakfast sandwiches, and requested less carrots as a side. The council minutes again made no mention the residents had expressed concerns regarding the tenderness of the meat, the menu plan, or that they had requested the presence of the DM at the Resident Council meeting. Interview on 6/24/26 at 3:21 p.m., with the DM identified she was aware of some concerns that came from resident council. The AD communicated the concerns through email and the DM said she does what she can to address those concerns. She Identified she was aware the council had some concerns and wanted her to attend the meeting, but she had not been able to because she is only at the facility 3 days a week and has had staffing shortages in the kitchen that she had been covering. Review of the 3/30/26, email sent from the AD to the DM identified resident council was requesting grilled foods, breakfast for dinner, fresh fruits, baked potatoes, a waffle bar, (continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and ice cream sundae bar. The DM replied saying they could possibly grill food once weekly, fresh fruits will be coming on the spring/summer menu soon, potato choices will be changing, waffle bar could be an activity and snack, and they could do a sundae bar. The email made no mention that the Resident Council had concerns regarding the meat or that they wanted the DM to attend the meeting. Interview on 6/25/26 at 9:00 a.m., with the Activity Director, identified when the Resident Council brings concerns to the meeting, she would reach out to the appropriate department manager by email. If she had not received a response within a week, she would follow up with them again. Once she received a response she would follow up with the council at the next meeting. She identified she did not get all the council's concerns or the DM's response documented in the resident council meeting minutes. She reviewed the Resident Council process policy and identified that there was a form she was not aware of that was to be used, and stated she would be using that for documentation going forward. Interview on 6/25/26 at 11:18 a.m., with the director of nursing (DON) identified it is her expectation that the AD document any concerns and the resolution in the Resident Council meeting minutes and bring the information back to the Resident Council to be reviewed at the next meeting. Review of February 2026, Resident Council policy identified a designated staff will facilitate and record meeting minutes per council approval. Previous meetings minutes, including department responses, will be read at the beginning of the resident council meeting for resident approval. Designated staff will follow the Resident Council Agenda to record resident concerns, comments, questions, and suggestions. Resident council minutes will be shared with the department leaders once per month and concerns will be addressed in writing. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the medical director (MD-A) attended QAPI meetings for 4 of 4 quarters. Findings include: Review of the QAPI meeting minutes submitted for the months of June, August, Sept and [DATE], and Jan and April 2026, identified the facilities quarters were Quarter 1: July-Sept, Quarter 2: Oct-Dec, Quarter 3: Jan-March, and Quarter 4: April-June. Of the months submitted, in:June 2025: MD-A is listed on the attendance sheet, but he had not signed off as having attended the meeting.The remaining months of August, September and October 2025, and January and April 2026, MD-A's name was not on sign in sheet and there was no evidence to support he attended at least quarterly as required. Interview on 6/25/26 at 1:11 p.m., with the director of nursing (DON) identified she had overseen QAPI since January 2026. In review and discussion of the above meeting minutes/agendas, she agreed MD-A was not in attendance at any of their QAPI meetings. The DON agreed the facility needed to ensure the medical director was attending as required. Review of the February 2026, QAPI policy identified the QAPI committee was to include the medical director and other appropriate staff. QAPI was to meet at least 4 times per year to oversee and direct facility activities. There was no mention in the policy of how to ensure the medical director (or his or her appropriate designee) attended meetings as required. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to determine whether a resident was safe to self-administer 2 nebulized medications for 1 of 1 resident (R6) who received 2 medications administered by nebulizer. Findings include: Observation on 6/25/26 at 8:41 a.m. as licensed practical nurse (LPN)-A administered R6's two ordered nebulized medications identified LPN-A assembled the nebulizer mask, tubing, and medication cup, emptied the single dose vial of Arformoterol Tartrate (a long-acting bronchodilator prescribed for the long-term twice daily maintenance treatment of airflow blockage), 15micrograms (mcg)/2milliliters (ml) into the nebulizer medication cup, attached the medication to the mask and positioned the mask on R6's face. He turned on the nebulizer and left the room while R6 received her medication dose. Prior to leaving the room, LPN-A informed R6 he would return in 10 minutes to give the 2nd medication. R6 was on her back in bed with the head of her bed elevated and did not reply as LPN-A left the room Observation on 6/25/26 at 8:53 a.m., identified LPN-A returned to R6's room, turned off the nebulizer, added the single dose vial of Budesonide (a liquid corticosteroid used to decrease airway inflammation) 0.5miligram(mg)/2ml to R6's nebulizer medication cup, and reapplied the mask, after turning on the nebulizer machine. He then verbalized he would return in 10 minutes to discontinue the treatment. LPN-A then left the room as R6 was receiving her treatment. Interview on 6/25/26 at 8:55a.m. with LPN-A reported he did not believe R6 had an order on file to self-administer her nebulized medications, but he felt it was acceptable to leave her unattended during administration of her nebulizer medications. Subsequent interview at 9:57 a.m. with LPN-A identified he had checked the medical record and R6 did not have an order to self-administer her nebulized medications, and as a result he should have remained in attendance during the administration. Interview on 6/25/26 at 10:02 a.m. with registered nurse (RN)-A identified case managers were responsible for completing assessments for residents to self-administer medications, including nebulized medications. Upon review of R6's medical record two previous assessments for self-administration of medication had been completed since her admission on [DATE], and neither identified she was competent to self-administer her medications. Interview on 6/25/26 at 3:55 p.m., with the director of nursing (DON) identified her expectation for self-administration assessments to be completed for all residents prior to allowing them to remain unattended during administration of any medications. Review of the June 2026, Self-Administration of Medications policy identified an assessment was to be completed and reviewed by the interdisciplinary team (IDT). An assessment was to be completed quarterly, if there was a change in medical condition, mental status, or as needed. The results were to be documented in the resident's medical record and care plan. Documentation of a physician order for self-administration was to be obtained and include which medications the resident was able to self-administer. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on interview and document review, the facility failed to ensure a timely review with a rationale for a as needed (PRN) psychoactive medication was completed for 1 of 7 sampled residents (R10). Additionally, the facility failed to ensure target symptoms/behaviors were identified for an antidepressant medication to ensure monitoring for effectiveness for 1 of 7 sampled residents (R3). Findings include: R10's 5/13/26, accepted quarterly Minimum Data Set (MDS) assessment identified R10's cognition was intact. R10 had diagnoses of heart failure, high blood pressure, renal insufficiency (kidney disfunction), and seizure disorder. There were no identified diagnoses of anxiety. R10's 3/27/26, physician's Comfort Kit order identified lorazepam (antianxiety medication) 0.5 milligrams (mg) orally every 4 hours PRN for anxiety. If anxiety not improved in 1/2 hour, staff may repeat one time. R10's 6/24/26, printed Medication Administration Record (MAR) identified an order for lorazepam 0.5 mg every 4 hours PRN, comfort measures only with no end date identified. Interview on 6/24/26 at 10:18 a.m., with registered nurse (RN)-C identified that R10 had an order for lorazepam with no end date, because she was currently on comfort cares (end of life treatment). The pharmacist continued to make recommendations to establish an end date or review date and that was done every 30 days for R10's lorazepam. She confirmed the pharmacist had made a recommendation on 5/22/26,to identify a rationale to continue R10's lorazepam PRN order or discontinue. RN-C stated she noted the recommendation on 5/27/26 and took the recommendation physically to the physician's office connected to the facility. RN-C said with the transition to the new electronic record system, she had forgotten to check on the status of the pharmacy recommendation. Typically, she would have followed up with the physician regarding pharmacy recommendations that had not been addressed. She reported she had walked over to the physician's office today (6/24/26) and found that the pharmacy recommendation was laying in a pile of papers on a desk and had not been reviewed yet by the physician. The physician did review and documented for staff to continue for 3 more months. She confirmed that the last review had been done on 4/9/26 for 60 days and that the lorazepam PRN order should have been addressed no later than 6/8/26, 17 days ago. She revealed that R10's lorazepam 0.5 mg PRN order had come from the order for a comfort kit due to R10's declining health and wanting to be kept comfortable. The facility had obtained the order for the comfort kit to ensure they had medications available if needed. Interview on 6/25/26 at 11:10 a.m., with the director of nursing (DON) identified the facility has had some concerns with providers acting timely on pharmacy recommendation and that had addressed at the provider meetings. The facility has had to keep on the providers to get pharmacy recommendations addressed timely. The DON reported that with the recent mitigation to the new electronic record system, the facility must not have followed up with the provider to ensure the pharmacy recommendation was acted upon timely for R10. A policy on PRN psychoactive medications was requested but not provided. R3's admission record identified she admitted to the facility in February of 2024. R3's 5/13/26, accepted comprehensive Minimum Data Set (MDS) assessment identified R3 cognition was intact. R3 had diagnoses of anemia, atrial fibrillation, coronary artery disease, renal insufficiency, arthritis, thyroid disorder, and depression. R3's current physician order identified Celexa 20 milligrams (mg) every day with no associated diagnosis. Review of R3's medical record identified that the Celexa was last increased on 1/8/26 from 10 mg to 20 mg. There was no indication of target symptoms/behaviors for the Celexa. R3's undated, care plan identified although there was a section on R3's psychosocial well-being with a goal to demonstrate her ability to cope with her hospitalization/illness, there was no mention of R3 having existing depression or taking an antidepressant medication with any identified target symptoms/behaviors that may increase with end of life, or for monitoring for the effectiveness of the antidepressant. Interview on 6/25/26 at 11:34 a.m. with registered nurse (RN)-B confirmed that R3 had nothing on her care plan that identified R3 had depression or that she was taking an<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | antidepressant medication and no mention of target symptoms/behaviors that the antidepressant medication was treating for monitoring purposes. The target symptoms/behaviors were typically identified on the care plan. Interview on 6/25/26 at 4:17 p.m., with the director of nursing (DON) identified that each resident receiving a psychoactive medication should have target symptoms/behaviors identified for monitoring for effectiveness of the medication. A policy was requested for psychoactive medication was requested but not received. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on interview and document review the facility failed to notify the ombudsman of a discharge for 1 of 2 sampled residents (R52). Findings include: R52's 4/22/26, accepted discharge Minimum Data Set (MDS) assessment identified R52 had been discharged to home/community with return not anticipated. R52's 4/16/26, discharge summary identified that R52 had discharge with home health services following completing therapy services. Interview on 6/25/26 at 3:30 p.m., with registered nurse (RN)-A and social service designee (SSD) both identified the facility only notified the ombudsman when there was an emergency discharge to the hospital or a resident leaves the facility against medical advice. The SSD reported the facility did not notify the ombudsman of any planned discharges and confirmed the ombudsman was not notified for R52's discharge back to the community. Interview on 6/25/26 at 4:17 p.m., with director of nursing (DON) identified she was unaware that the facility had not been notifying the ombudsman about all discharges. She confirmed the facility had a policy and it identified to notify the ombudsman of all discharges. Review of December 2025, Transfer or Discharge Notice policy identified a copy of a transfer or discharge would be sent to the ombudsman. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on interview and document review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 5 sampled residents (R3) with a diagnosis of depression.Findings include: R3's admission record identified she admitted to the facility in February of 2024. R3's 5/13/26, accepted comprehensive Minimum Data Set (MDS) assessment identified R3 cognition was intact. R3 had diagnoses of anemia, atrial fibrillation, coronary artery disease, renal insufficiency, arthritis, thyroid disorder, and depression. R3's current physician order identified Celexa 20 milligrams (mg) every day. Review of R3's medical record identified that the Celexa was last increased on 1/8/26 from 10 mg to 20 mg. R3's undated, care plan identified although there was a section on R3's psychosocial well-being with a goal to demonstrate her ability to cope with her hospitalization/illness, there was no mention of R3 having existing depression or taking an antidepressant medication with any identified target symptoms/behaviors that may increase with end of life, or for monitoring for the effectiveness of the antidepressant. Interview on 6/25/26 at 11:34 a.m. with registered nurse (RN)-B identified the facility care plans were still a work in progress as the facility had just switched to a new electronic medical record system. She confirmed that R3 had nothing on her care plan that identified R3 had depression or that she was taking an antidepressant medication. There were no target symptoms/behaviors that the antidepressant medication was treating for monitoring purposes. The care plan lacked what staff are to do as interventions if R3 displayed symptoms of depression and normally all that information would be addressed on the resident's care plan. RN-B identified R3 had started the antidepressant prior to admission to the facility. Interview on 6/25/26 at 4:17 p.m., with the director of nursing (DON) identified that each resident should have a person-centered care plan developed. R3's care plan should have addressed her depression and what her target symptoms/behaviors were and what staff were to do if she displayed those behaviors. She agreed target symptoms/behaviors should be identified in order to monitor for effectiveness of the medication. Review of July 2025, Care Plan policy identified a resident's care plan would be developed by the interdisciplinary team including participation by the resident. The resident's care plan would include medications used as an intervention for the residents' medical needs. The residents' care plan would be updated as needed and reviewed at minimum quarterly. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on interview and document review, the facility failed to revise the care plan for 1 of 13 sampled residents (R10) with a diagnosis of end stage kidney disease. Findings include: R10's 5/13/26, accepted quarterly Minimum Data Set (MDS) assessment identified R10's cognition was intact. R10 had diagnoses of heart failure, high blood pressure, renal insufficiency (kidney dysfunction), chronic kidney disease, and end stage renal disease. R10's 5/20/26, physician visit note identified consideration for palliative/hospice care had been previously discussed. R10 was interested in this when the time comes for her kidneys. She anticipated that her nephrologist would inform her of that. R10's 6/11/26, nephrology visit note identified chronic kidney disease, stage 4 with bilateral hydronephrosis (enlarged kidney affecting the body's ability to excrete urine), pyuria (pus in urine), and hematuria (blood in urine). Different forms of renal replacement therapy were discussed, and it was noted R10 had declined dialysis. R10's current, undated care plan identified staff were to watch for signs and symptoms of bladder infection, however; there was no mention R10 had end stage kidney disease or that R10 had declined dialysis treatment and chose to remain comfortable at the facility or what staff should watch for if her kidneys failed to operate and function. Interview on 6/25/26 at 11:10 a.m., with the director of nursing (DON) identified each resident should have a person-centered care plan. The care plan should be reviewed and revised as needed as care needs change. She agreed that when R10 had declined the dialysis treatment and requested to be kept comfortable at the facility that the facility should have updated R10's care plan to reflect that change. Review of July 2025, Care Plan policy identified a resident's care plan would be developed by the interdisciplinary team including participation by the resident. The residents' care plan would be updated as needed and reviewed at minimum quarterly. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>Based on observation, interview and document review, the facility failed to ensure staff followed the facility policy to appropriately verify gastrostomy (G) tube placement prior to feedings and medication administration for 1 of 1 resident (R6) reviewed with a feeding tube.Findings include: R6's 5/24/26 accepted quarterly Minimum Data Set (MDS) assessment identified she had moderate cognitive impairment, required staff assistance for all activities of daily living (ADLS), had impairment of upper and lower extremities, and used a wheelchair for mobility. She had a feeding tube in place and received 51% or more of her total calories through the feeding tube. Average fluid intake was 501cc or more per day via the feeding tube. R6 received crushed medication via the feeding tube including an antidepressant, diuretic, opioid, blood pressure, medication for acid reflux, nausea and antiplatelet medications. R6 was admitted in February 2026, with diagnoses of oropharyngeal dysphagia (difficulty initiating a swallow from the mouth into the throat, feeding by G-tube, severe physical deconditioning, and cognitive impairment. She was admitted with a (gastric tube-PEG -a surgically placed tube through the abdominal wall directly into the stomach), and orders for Isosource (lactose-reduced food) with fiber 0.07 grams/1.5 kilo (k) calorie (Cal)/milter (ml) 900 ml/day. Free water was to be administered five times daily at 300 ml via PEG tube. Free water flush 300 ml via G-tube bolus four times daily (QID). Give 150 ml before feeding/medication and 300 ml all other times. R6's current, undated care plan identified she was at risk for impaired nutritional status, evidenced by the need for G-tube feedings. The identified goal was maintaining nutritional status and avoiding weight loss. R6 was to be weighed weekly. Feeding was identified as 900 ml of Iso-source 1.5 formula with a note to refer to orders for further details. Positioning: keep patient upright (30-45 -degree angle) during feeding and for 30-60 minutes afterward to prevent aspiration. Flushing: flush the tube with 150ml of warm water before and after each feeding or medication administration. May have risk for dehydration related to being on tube feedings. Follow registered dietitian recommendations for free water flushed. Notify the provider for tube dislodgement or concerns with patency. Observation on 6/25/26 at 8:23 a.m., with licensed practical nurse (LPN)-A as he prepared to administer R6's physician ordered medications. LPN-A checked the orders for medications, set-up and crushed each medication, placing them into a medication cup. He then took the medications to R6's room applied personal protective equipment (PPE), washed his hands and applied gloves. He explained to R6 he had her medications to administer through her G-tube. LPN-A retrieved a graduated container and filled it with 300 ml of tap water. He then mixed 90 ml of water into the crushed medication. He elevated the head of the bed to 45 degrees. LPN-A exposed R6's feeding tube, opened a 30 ml syringe, removed the plunger and inserted the syringe into the G-tube port. He opened the stop cock and reported he did that to let any air escape. LPN-A poured 90 cc of water in 30 ML intervals and allowed it to flow via gravity. When LPN-A opened the stop cock to allow air to escape a small amount of liquid was noted where the tube entered the abdomen. LPN-A continued to administer the water, then poured the medications into the G-tube and flushed with the remaining water. He then re-clamped the G-tube and told R6 he had also given her medication for nausea with her other medications LPN-A reported this was the normal procedure he followed for administering R6's medications and water. When finished LPN-A took the graduated container and syringe into the bathroom and rinsed and then placed on a paper towel to air dry. Interview on 6/25/26 at 8:43 a.m. with LPN-A identified he did not routinely check G-tube placement before administering medications or water, as he did not believe he needed to. He further stated when the tube had been changed the placement had been verified by x-ray. When asked about any fluid in the G-tube he reported he thought there was some liquid from the last feeding that came out when the air went out the tube, but he was not certain. Interview on 6/25/26 at 10:02 a.m., with registered nurse (RN)-A reported she did not think they were still supposed to check for G-tube placement prior to administration of medications or (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<br>B. Wing | 06/25/2026 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | fluids, but she would need to check the policy to see what it directed. Interview on 6/25/26 at 3:55 p.m., with the director of nursing (DON) reported she thought there was a provider order for R6 that they did not need to check placement for her G-tube. She stated she thought this was because R6 had the G-tube for a long time. Review of the current physician orders with the DON failed to identify an order regarding checking placement of R6's G-tube. Review of the August 2025, policy Gastrostomy tube, PEG (Percutaneous Endoscopic Gastrostomy) tube care identified the Procedure:Place equipment and supplies at bedside where they will be easily accessed.Perform hand hygiene, [NAME] clean gloves.Observe and document external bumper length, verifying the bumper has not migrated. There should be approximately 1 centimeter (cm) between the skin and external bumper. Administering a feeding/checking placement Remove the tube cap or plug by closing the tube. Use a syringe to inject 5-10 ml of air into the tube to clear it.Aspirate gastric contents with the syringeConnect the syringe and infuse water, feeding and or medicationsOnce administration is completed flush with water according to MD order.Document time, feeding if administered, water, and amount administered, tolerance to administration, appearance of skin surrounding the tube, tube patency, and verification of tube placement. Medication Administration:Medications as ordered by providerThe amount of flush to be ordered by the MD.Liquid dosage forms are preferred if possible, and pharmacy will determine if ordered medications can be crushed. Liquefy medications in 15-30 ml of water. Check proper placement of the G-tube prior to administration.Flush the tube with water prior to and following administration of the medicationDocument medication administration |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R48) discontinued controlled narcotic medication was not stored with in-use medications in 1 of 2 medication carts.Findings include: Observation and physician order review on 6/24/26 at 2:30 p.m. with licensed practical nurse (LPN)-B and trained medication aide (TMA)-A as they performed the shift change narcotic count in 1 of 2 medication carts identified there was 1 blister pack card containing 30 Lorazepam 0.5milligram (mg) tablets with the printed pharmacy label identifying it had been dispensed on 6/2/26 for R48. The physician order recorded in the electronic medical record identified the order for Lorazepam 0.5mg by mouth (PO) every (Q) 6 hours (H) as needed (PRN) with a start date of 6/2/26 and the medication was discontinued on 6/16/26. Interview on 6/24/26 at 2:40 p.m. with LPN-B and TMA-A identified the card containing R48's Lorazepam had remained in the in-use narcotic box located on the medication cart co-mingled with other in-use medications and noted it should have been removed and destroyed when the order was discontinued. Interview on 6/24/26 at 2:49 p.m. with registered nurse (RN)-A identified the procedure when a controlled medication was discontinued was the nurse on duty should have pulled the discontinued medication from the active medications and destroyed with two nursing staff in attendance. Interview on 6/24/26 at 3:12 p.m. with the director of nursing (DON) identified when a controlled medication was discontinued it should be removed from the active medication and destroyed with two nursing staff in attendance. A policy for storage and disposal of controlled medications was requested but not received by the end of the survey period. |