STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johnson Memorial Hosp & Home	1290 Locust Street Dawson, MN 56232

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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 0657 Level of Harm - Minimal harm or potential for actual harm 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. 47497 Based on interview and record review, the facility failed to ensure 1 of 14 residents (R47) care plan was revised to identify that she had an actual elopement event. Findings include: Review of the report to the State Agency (SA) identified on 5/27/24 at 11:10 a.m., R47 was observed by another resident exiting the building without staff knowledge. Once notified, facility staff acted and found R47 approximately 10 feet from the door. R47 had been wearing a WanderGuard bracelet however, staff identified the door did not engage the lock and the alarm did not sound per normal when a resident wore a WanderGuard. R47's 11/22/24, annual Minimum Data Set (MDS) assessment identified her cognition was severely impaired. R47 had diagnoses of Alzheimer's dementia, delirium, and disorientation. R47 was noted to be independent with transfers and required extensive assistance with dressing and hygiene. R47 wore a wander/elopement alarm. R47's care plan identified she was at risk for elopement and had a history of attempts to leave the facility unattended and had impaired safety awareness. R47 wore a wander-guard and staff were to offer pleasant diversion, take R47 out to the courtyard when weather permitted, and check the WanderGuard function every shift. The care plan lacked update or revision following the 5/27/24 elopement to include potential new interventions such as increased supervision etc that was identified by staff. Interview on 2/20/25 at 10:04 a.m., with registered nurse (RN)-D reports they keep an eye on her when she is wandering. She had no knowledge of R47 having successfully eloping from the building on 5/27/24. Interview on 2/20/25 at 10:07 a.m., with nursing assistant (NA)-A identified if R47 is wandering a lot they keep the doors leading off the unit closed. Staff offer snacks or a warm blanket to try and get her to sit for a while and when the weather is nice, they offer to take her out on the courtyard. NA-A had no knowledge of R47's actual elopement event. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/20/25 at 11:00 a.m., with director of nursing identified she agreed the facility had ensured they updated the care plan to notify staff of an actual elopement and new interventions to prevent reoccurrence. She agreed that should have been done and was not sure why staff failed to do it. Review of the April 2024, Comprehensive Person-Directed Care Plan and Baseline Care Plan Policy identified revisions to the care plan should be added as the resident's condition changes in order to address current problems.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336 Based on observation, interview, and document review, the facility failed to ensure all 9 licensed nurses (registered nurse (RN)-A, RN-C, RN-D, RN-G, RN-I, licensed nurse (LPN)-A, LPN-B, LPN-C, and LPN-D) and all 5 agency licensed nurses (RN-E, RN-J, RN-K, LPN-E, and LPN-F) who administer or had the potential to administer insulin were appropriately trained and deemed competent to facility policy and manufacturer's instructions for insulin administration. This had the potential to affect all residents who recieved insulin. Findings include: Review of the [DATE], report to the facility identified R106 was scheduled to receive 36 units of Basaglar (a long-acting insulin). The staff nurse attempted to document R106's insulin administration on the medical record and realized R106 had actually received 36 units of Fiasp (a short acting insulin), instead. The staff nurse reported the incident to R106's primary provider and was directed to monitor R106 blood sugars. R106's face sheet identified R106 was admitted [DATE] with a diagnosis of diabetes. R106's, February Medication Administration Record identified R106 was to receive 36 units of glargine twice a day for diabetes and Fiasp sliding scale insulin according to blood sugar levels listed as: ,d+[DATE] = 0 units, ,d+[DATE] = 2 units. Staff were to give subcutaneously (fat layer between the skin and muscle) 3 x per day. R106's undated, current care plan identified staff nurses would administer diabetic medication as ordered, monitor/document for side effects and effectiveness of the medication, monitor/document/report as needed signs and symptoms related to low blood sugar levels such as sweating, tremors, confusion, slurred speech. Review of [DATE] Medication Administration Protocol policy identified the facility nursing staff would follow medication rights before, during and after medication administration, as followed: 1) Patient verification 2) Right medication 3) Right dose 4) Right route 5) Right time 6) Right documentation 7) Right reason (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8) Right response 9) medication not expired Staff nurses were to ensure medication, such as, insulin would be labeled with an open and discard date, according to manufacturer's instructions. Lastly, staff nurses were to check expiration dates of medications during administration times. Interview on [DATE] at 2:02 p.m., with R106 identified staff nurse informed him he was given the incorrect insulin and was to be monitored throughout the night. R106 stated he did not experience any side effects from the administration of the incorrect insulin. Interview on [DATE] at 5:12 p.m., with the director of nursing (DON) identified there was no formal checklist that would include licensed nurse staff being trained on insulin administration. She had no copies of employee training accessible on file to identify insulin training or competencies had been completed and licensed nurses would be trained on the job alongside other colleagues on the unit by nurse managers. DON stated in services were held at the facility that was directed at insulin administration, however, audits were not completed. Review of [DATE] In-Service Education policy identified continuing education and training for employees would meet regulatory and licensing requirements. New employee was to complete initial training upon hire and annual training was to be completed for all employees based on department needs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336 The facility failed to administer insulin according to physician orders and manufacturers instruction for 1 of 1 (R106) resident who was administered the wrong insulin. Findings include: Review of report to the State Agency on [DATE] at 9:00 p.m., identified R106 was scheduled to receive 36 units of Basaglar (a long-acting insulin). The staff nurse attempted to document R106's insulin administration on the medical record and identified they made an error and R106 had received 36 units of Fiasp (a short acting insulin) instead. The staff nurse reported the incident to R106's primary provider and was directed to monitor R106 blood sugars. R106 face sheet identified they were admitted [DATE] with a diagnoses of Alzheimer's, dementia with psychotic disturbance, depression and diabetes. R106's, February Medication Administration Record identified R106 was to receive 36 units of glargine twice a day for diabetes and Fiasp sliding scale insulin, give ,d+[DATE]= 0 units, ,d+[DATE]= 2 units, give subcutaneously (the fat layer between the skin and muscle) three times a day. R106's undated, current care plan identified staff nurses would administer diabetic medication as ordered, monitor/document side effects and effectiveness of the medication, monitor/document/report as needed, sign and symptoms related to hypoglycemia, such as sweating, tremors, confusion, slurred speech, and refer to podiatrist/foot care nurse to monitor/document foot care needs. Interview on [DATE] at 1:12 p.m., with RN-C identified it was not appropriate practice for staff nurses to administer insulin to residents without following medication rights and expiration dates of medication before administration. RN-C could not recall having demonstrated competency as part of hire or annually. Interview on [DATE] at 2:02 p.m., with R106 identified staff nurse informed him he was given the incorrect insulin and was to be monitored throughout the night. R106 stated he did not experience any side effects from the insulin. Review of [DATE] Medication Administration Protocol policy identified the facility nursing staff would follow medication rights before, during and after medication administration, as followed: 1) Patient verification 2) Right medication 3) Right dose 4) Right route (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) Right time 6) Right documentation 7) Right reason 8) Right response 9) Verify the medication had not expired Interview on [DATE] at 5:12 p.m., with the director of nursing (DON) identified there was no formal checklist that would include licensed nurse staff being deemed competent upon hire or annually on insulin administration. She had no copies of employee training accessible on file to identify insulin training or competencies had been completed and licensed nurses would be trained on the job alongside other colleagues on the unit by nurse managers. DON stated in services were held at the facility that was directed at insulin administration, however, audits were not completed. Review of [DATE] In-Service Education policy identified continuing education and training for employees would meet regulatory and licensing requirements. New employee was to complete initial training upon hire and annual training was to be completed for all employees based on department needs.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336 Based on observation, interview, and document review, the facility failed to follow manufacturer's instructions and label insulin pens with an open and discard date for 6 of 6 residents (R7, R23, R28, R29, R51, and R106) sampled insulin pens. Findings include: Observation on [DATE] at 11:37 a.m., with registered nurse (RN)-G, on Prairie Lane hall, reviewed R23's insulin order on Point Click Care (PCC) an online electronic medical record identified R23 was to receive 5 units of Lantus (a long-acting) insulin that was to be given daily at 11:00 a.m. RN-G removed the insulin pen from R23's medication cupboard and read the label. RN-G had sanitized her hands, applied gloves, and administered the insulin. RN-G documented on R23's medication chart in PCC. The label on the insulin pen had an open date of [DATE]. There was no discard date labeled on the insulin pen. Observation on [DATE] at 11:41 a.m., with RN-G, on Prairie Lane Hall, reviewed R29's blood sugar reading from her portable glucometer phone and confirmed R29's blood sugar was 243. RN-G reviewed R29's insulin order identified R29 was to receive Humalog sliding scale insulin from ,d+[DATE]= 4 units, etc. RN-G informed R29 her blood sugar was under 250 and did not require insulin. RN-G opened R29's medication cupboard and removed 2 insulin pens Neither pen had an open or discard date on the label. Both pens were actively in service. Observation on [DATE] at 11:45 a.m., with RN-G, on Prairie Lane Hall, reviewed R28's blood sugar reading from his portable glucometer phone and confirmed R28's blood sugar was 171. RN-G reviewed R28's insulin order identified R28 was to receive Humalog sliding scale insulin ,d+[DATE]= 2 units and informed R28 he was to receive 2 units of insulin. R28 requested the insulin to be placed in his abdomen. RN-G administered the insulin per order. RN-G documented the administration in R28's medical record. R28's Humalog insulin pen had an open or discard date on the label. Further observation on [DATE] at 12:05 p.m., identified the following: 1) R7's lantus insulin pen had no open or discard date on the label. 2) R28's lantus insulin pen had an open date of [DATE] but no discard date and their Humalog insulin pen had no open or discard date on the label. 3) R29's Lantus insulin pen had no open or discard date on the label 4) R51's glargine insulin pen had no open or discard date on the label. 5) R106's Fiasp insulin pen had a open date of [DATE] but no discard date and a glargine insulin pen had no open or discard date on the label. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 12:44 p.m., with RN-A identified staff nurses were to label the insulin pen with an open and discard date once it was removed from the fridge to ensure staff nurses identify when the insulin pen was to expire. Interview on [DATE] at 1:12 p.m., with RN-C identified insulin pens that were not dated appropriately would be discarded and replaced with a new pen from the fridge. She identified it was not appropriate practice for staff nurses to administer insulin to residents without following medication rights and expiration dates of medication before administration. Interview on [DATE] at 5:12 p.m., with the director of nursing (DON) identified she expected staff to follow manufacturer's guidelines identifying staff were to write open and discard dates on insulin pens. Review of [DATE] Medication Administration Protocol policy identified the facility nursing staff would follow medication rights before, during and after medication administration, as followed: 1) Patient verification 2) Right medication 3) Right dose 4) Right route 5) Right time 6) Right documentation 7) Right reason 8) Right response 9) Ensure medication was not expired Staff nurses were to ensure medication, such as, insulin would be labeled with an open and discard date, according to manufacturer's instructions. Lastly, staff nurses were to check expiration dates of medications during administration times.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 39988 Based on interview and document review, the facility failed to implement 1 of 1 facility assessment and ensure the identified number of staff deemed required to provide care and services to residents had been scheduled and maintained on the weekends. Findings include: Review of the 8/8/24, Facility Assessment identified resources needed to provide care and competent support to the residents residing in the facility daily included staffing plan of: 1. Days-weekdays registered nurse (RN) 24 hours, licensed practical nurse/trained medication aide (LPN/TMA) 24-hour, nursing assistant (NA) 45-54 hours, director of nursing/assistant director of nursing (DON/ADON) 16 hours. 2. Days-weekends RN 12 hours, LPN/TMA 12 hours, NA 54 hours 3. Evenings -weekday RN 0 hours, LPN/TMA 16 hours, NA 37-42 hours 4. Evenings-weekend RN 0 hours, LPN/TMA 16 hours, NA 54 hours 5. Nights-weekdays RN 12 hours, LPN/TMA 0 hours, NA 24 hours 6. Nights- weekends RN 12 hours, LPN/TMA 0 hours, NA 32 hours Review of the 6 sampled weekend dates identified on: 1) 7/6/24 day shift RN-12 hours, LPN/TMA 12 hours, NA 44 hours (should have been 54 hours) evening shift- LPN/TMA 12 hours, NA 42 hours (should have been 54 hours), night shift RN 12 hours, NA 24 hours (should have been 32 hours). 2) 7/7/24-day shift RN-12 hours, LPN/TMA 12 hours, NA 47 hours (should have been 54 hours) evening shift LPN/TMA 12 hours, NA 43 hours (should have been 54 hours) night shift RN 12 hours, NA 24 hours (should have been 32 hours). 3) 8/17/24 day shift RN-12 hours, LPN/TMA 17 hours, NA 53 hours, evening shift LPN/TMA 12 hours, NA 35 hours (should have been 54 hours) night shift RN 12 hours, NA 17 hours (should have been 32 hours). 4) 8/18/24 day shift RN-12 hours, LPN/TMA 17 hours, NA 45 hours (should have been 54 hours) evening shift LPN/TMA 12 hours, NA 41 hours (should have been 54 hours) night shift RN 12 hours, NA 25 hours (should have been 32 hours). (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5) 9/28/24 day shift RN-12 hours, LPN/TMA 15 hours, NA 58 hours evening shift -LPN/TMA 12 hours, NA 59 hours, night shift RN 12 hours, NA 24 hours (should have been 32 hours). 6) 9/29/24 day shift RN-12 hours, LPN/TMA 12 hours, NA 47 hours (should have been 54 hours) evening shift -LPN/TMA 16 hours, NA 54 hours, night shift RN 12 hours, NA 24 hours (should have been 32 hours). Interview on 2/20/25 at 10:05 a.m., with DON identified the previous interim administrator had determined the staffing needs. Following review of the facility assessment for staffing needs the DON confirmed that the assessment needed to be reviewed and revised as the hours should be the same on weekdays and weekends. The DON agreed that the required staffing hours identified on the facility assessment had not been met on the weekend shifts sampled in quarter 4. There was no additional policy related to staffing provided by the end of the survey.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 39988 Based on document review and interview, the facility failed to submit complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data, during 1 of 1 quarter reviewed (Quarter 4) 2024 (July 1 - September 30) to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. Findings include: Review of the Payroll Based Journal Report (PBJ) [NAME] Report 1705D identified excessively low weekend staffing had triggered. Review of the schedules and staff timecards identified on 7/6/24 registered nurse (RN)-E a contracted nurse had worked a 12-hour shift. RN-E had not clocked in on the facilities system to track hours worked for the PBJ report. On 8/17/24 RN-F, a hospital nurse who worked at the care facility in an on-call basis, had worked an 8-hour shift. Interview on 2/20/25 at 10:05 a.m., with director of nursing (DON) identified that staff punch in with a code, she was not sure how the on-call hospital staff punched in though. She thought the hospital staff punched in the same way they always do and was unsure if the time correctly was allocated to the nursing home hours. She confirmed that RN-E had worked on 7/6/24 and had failed to punch into the facility system so those hours would not have transferred to the PBJ report. She confirmed that the PBJ report was inaccurate related to RN-E not punching into the facility system. Interview on 2/20/25 at 10:15 a.m., with the payroll coordinator revealed he submitted the hours for PBJ however, he did not run any reports to verify there were no inaccuracies. He understood he only needed to review to ensure there was an RN working 8 hours each day. A policy was requested on PBJ reporting however, the DON reported the facility had no policy on PBJ reporting.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47497 Based on interview and document review, the facility failed to ensure appropriate oversight by the infection preventionist (IP) and follow up when multiple departments heads consistently failed to report required surveillance data used in tracking employee illness for 33 of 60 (unidentified in the tracking) facility staff and note return to work dates for 3 months reviewed (November 2024 through January 2025). This had the potential to affect all 55 residents at the facility. Findings include: Review of the November 2024, December 2024, and January 2025, staff surveillance identified: 1) November 2024: 8 staff called in sick. 2 with cold symptoms, 2 with nausea, 1 with fever, 1 with a rash, and 1 with a headache. 2 of the 8 staff that called in sick lacked a return to work date. 2) December 2024: 18 staff called in sick. 4 with diarrhea, 7 with cold symptoms, 1 with vomiting, 1 with nausea, 2 with abdominal pain, and 3 with other. 12 of 18 staff who called in sick lacked a return to work date. 3) January 2024: 28 staff called in sick. 4 with diarrhea, 11 with cold symptoms, 5 with vomiting, 1 with a headache, 5 with body aches, and 2 with other. 19 of 28 staff who called in sick lacked a return to work date. There were only departments noted in the report to which them employee worked. No names were noted which would identify potential specific areas or exposure to residents. Interview on 2/19/25 at 1:09 p.m., with the infection preventionist identified she agrees with the above findings. She has had difficulty getting other departments to submit information timely. She provides each department with a form in MS TEAMS (a communication application used for messaging and virtual meetings). Each department was expected to fill out the form and she would then transfer the information to the surveillance log. She identified that she has brought her concerns about the lack of reporting from department heads several times to IDT meetings. Interview on 2/19/25 at 5:17 p.m., with the administrator identified he was aware of the concern by the IP mentioned above, and had discussed those concerns had been discussed at the QAPI (Quality Assurance and Performance Improvement) meeting. He encouraged staff to start providing the information. He would expect the IP to provide retraining to the department heads if they were not providing the correct information and noted the IP should have reached out to the administrator if the concern continued. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility provided December 2024, Employee Illness Reporting policy identified staff were to report illness to their supervisor, the supervisor was to enter the information into Teams under Employee Illness. The information should include department, staff title, dates ill, nature of illness, return to work date, if seen by a provider, and if testing was completed. The IP was to document and trend the illnesses in an Infection Control Report and the information would be reported to QAPI quarterly. The facility policy lacked any indication the IP should identify who the individual staff that called in with illness to be able to provide accurate over sight and narrow down exposure to residents to be able to comprehensively.