



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 11, 2025

Administrator
Johnson Memorial Hospital & Home
1290 Locust Street
Dawson, MN 56232

RE: CCN: 245485
Cycle Start Date: February 20, 2025

Dear Administrator:

On February 20, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nicole Dahl, RN, Regional Operations Supervisor

Marshall District Office

Health Regulation Division

Minnesota Department of Health

1400 East Lyon Street, Suite 102

Marshall, Minnesota 56258-2504

Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 20, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 20, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245485	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2025
NAME OF PROVIDER OR SUPPLIER JOHNSON MEMORIAL HOSP & HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1290 LOCUST STREET DAWSON, MN 56232		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 2/18/25 through 2/20/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 2/18/25 through 2/20/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54857641C (MN109136). The following complaints were reviewed. H54857642C (MN103661) and H54857081C (110400) with deficiencies cited at F657 and F755. H54857641C (MN109136) was also reviewed. NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/20/2025

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.

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F 000	Continued From page 1	F 000			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 14 residents (R47) care plan	F 657		3/20/25	
			F657 Care Plan Time and Revision Social worker and ADON will be leads on		

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F 657	Continued From page 2 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	F 657	review and update of care plans on all residents identified as a wandering risk. Care plans of identified resident will be updated and presented at staff meetings on 3/18/25 and 3/20/25. Social worker and ADON will update staff on care plan revisions. Moving forward any resident elopement event will be reviewed by IDT team and care plan updated by social worker or RN designee as the lead with elopement date and care plan updated intervention. Wandering/Missing Resident policy reviewed and updated to link with Vulnerable Adult Prohibition policy and Care Center Abuse Prevention Plan, Comprehensive and Person-Directed Care Plan and Baseline Care Plan policy. Elopement audit will occur within 72 hours post event. Audit will include that an immediate intervention was placed and the care plan was reviewed to include elopement event date. Will report to QAPI quarterly on elopement events and plan as stated above.		

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F 657	Continued From page 3 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. 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.	F 657			
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 726			3/28/25

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F 726	Continued From page 4 accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: 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 1/31/25, report to the facility identified R106 was scheduled to receive 36 units	F 726	F726 Competent Nursing Services All nurses (LPN/RN) will be trained and have proven competency upon hire and annually thereafter on insulin administration per facility protocol. This will include staff nurses and agency nurses no matter what status of employment they are. Director of Senior Living Services will be referred to as DON for purposes of corrective action throughout document, will complete initial competency for all nurses starting 3/18/25 and all regularly scheduled nurses will have training completed prior to 3/28/25. Thereafter, DON or RN designee will complete all prn and new hire nurse competency on insulin administration to		

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F 726	Continued From page 5 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 January 2025 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: 70-199 = 0 units, 200-999 = 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 October 2022 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			F 726	ensure they are following facility protocol prior to beginning of next scheduled shift. Staff education completed at 3/18/25 and 3/20/25 staff meetings. Audit of all new hire nurses start date and completion of insulin competency prior to first independent shift worked will be completed and reported to QAPI quarterly. Please refer to Tag 755 Pharmacy Srvcs/Procedures/Pharmacists/Records for further corrective action on proper labeling and storage of medications.		

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F 726	Continued From page 6 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 2/18/25 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 2/19/25 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 August 2024 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.	F 726			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755			3/28/25

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F 755	Continued From page 7 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: 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 1/31/25	F 755	F755 Pharmacy Srcv-Procedures-Pharmacist-Records Staff education completed at 3/18/25 and 3/20/25 staff meeting and Medication Administration Procotol reviewed and updated to ensure compliance and resident safety. Specifically nurses staff and agency will complete upon hire and		

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F 755	Continued From page 8 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 January 2025 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 70-199= 0 units, 200-999= 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 2/18/25 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.	F 755	annually thereafter; staff competency will include insulin administration and insulin pens knowledge assessment. Current staff and upon hire nurses and TMAs including both staff and agency will complete knowledge assessments on medication administration overview and routes, blood glucose testing. Current nurses and TMAs both staff and agency will complete knowledge assessments and competencies by 3/28/25. If casual status nurse or TMA both staff and agency knowledge assessments will be completed by 3/28/25, however, nurse or TMA must schedule insulin administration competency and medication administration routes competency with DON or RN designee prior to working next scheduled shift. Please see corrective action plan for tags F726 and F761 corrective action audits and dates.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245485	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2025
NAME OF PROVIDER OR SUPPLIER JOHNSON MEMORIAL HOSP & HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1290 LOCUST STREET DAWSON, MN 56232		
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F 755	Continued From page 9 Interview on 2/18/25 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 October 2022 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) Verify the medication had not expired Interview on 2/19/25 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 August 2024 In-Service Education policy identified continuing education and training for employees would meet regulatory and	F 755			

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F 755	Continued From page 10			F 755			
F 758 SS=D	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. Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and			F 758			4/3/25

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F 758	Continued From page 11 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess and identify target behaviors or symptoms and non-pharmacological interventions for scheduled antidepressant and antipsychotic medication to ensure efficacy of the medication for 1 of 5 residents (R32) reviewed for unnecessary medication usage. Findings include: R32's 2/20/25, diagnosis list included generalized anxiety disorder, insomnia, major depressive disorder single episode, and unspecified psychosis not due to a substance or known physiological condition. R32's 1/8/25, quarterly Minimum Data Set (MDS) assessment identified R32's cognition was intact with no behaviors identified. R32 was independent with transfers and eating, R32 required assistance with some personnel cares.			F 758	F758 Psychotropic Meds/PRN Use Informed consents to be reviewed and updated to include target behaviors/symptoms for residents who receive psychotropic medications. Care plans to be reviewed and updated to reflect informed consent of target behaviors/symptoms for residents receiving psychotropic medications. All residents receiving psychotropic medications, will be reviewed and updated by 4/3/25. Staff education provided on 3/18/25 and 3/20/25 on monitoring care plans/kardex for specific target behaviors/symptoms related to individual residents. Consultant pharmacist attending and presenting at PAC (physician advisory council) education 3/19/25 related to ordering psychotropic medications in long term care setting to assure monitoring appropriate use and management of		

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F 758	Continued From page 12 R32 had frequent pain that he rated a 3 on scale of 1-10. R32 took a daily antipsychotic, antidepressant, antianxiety, diuretic, hypoglycemic, and opioid. R32's 7/16/24, significant change MDS identified R32 felt down, depressed, or helpless more than half of the days, had trouble falling asleep or staying asleep more than half of the days, and felt tired or had little energy more than half of the days. R32 had trouble concentrating and spoke slowly or felt fidgety or restless nearly every day. R32's Order summary Report identified the following orders: 1. Clonidine HCl 0.1 milligram (MG) three times a day for anxiety. 2. Fluoxetine HCl (Prozac) 80 mg every morning for major depressive disorder single episode. 3. Quetiapine Fumarate (Seroquel) 50 mg at bedtime for unspecified psychosis not due to a substance or known physiological condition. 4. Trazodone HCl 100 mg at bedtime for insomnia. There was no mention of symptoms or target behaviors that the psychoactive medications were prescribed to treat. R32's Anti-Psychotropic Medication Minimum Effective Dose Monitoring assessment identified: 1. Clonidine HCl 0.1 mg three times a day, diagnosis generalized anxiety disorder. Target symptoms reduce anxiety. 2. Fluoxetine HCl (Prozac) 80 mg, diagnosis major depressive disorder single episode. Target symptom was depression 3. Quetiapine Fumarate (Seroquel) 50 mg, diagnosis unspecified psychosis not due to a substance or known physiological condition. Target symptoms to decrease episodes of	F 758	psychotropic medications. When provider ordering a psychotropic medication order should include proper diagnosis and target behaviors that staff are to monitor for. Anti-psychotropic medication effective dose monitor JMHS & Psychopharmacological Assessment will be updated with next scheduled ARD date to reflect individualized target behaviors/symptoms for each psychotropic medication prescribed.		

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F 758	Continued From page 13 psychosis. 4. Trazodone HCl 100 mg, diagnosis insomnia, unspecified major depressive disorder single episode. Target symptoms insomnia, depression. There was no identification of specific symptoms that the medication had been ordered to treat. R32's Informed Consent for Psychotropic/Psychoactive Drug Use identified: 1. Clonidine 0.1 mg, diagnosis anxiety, target behaviors, anxiety and depression. 2. Fluoxetine (Prozac) HCl 80 mg, diagnosis major depressive disorder, target behaviors decrease symptoms of depression. 3. Quetiapine Fumarate (Seroquel) 50 mg at bedtime, diagnosis psychosis, target behaviors decrease psychosis episodes, help with sleep 4. Trazodone 100 mg at bedtime, diagnosis insomnia, target behaviors help with sleep. There was no identification of specific target behaviors that the medication had been ordered to treat. R32's undated care plan identified that R32 had depression and would remain free of signs or symptoms of distress, depression, anxiety or sad mood through the review date. Staff were to administer medications as ordered, monitor for side effects and effectiveness. There was no mention of target symptoms that staff were to monitor for effectiveness or any non-pharmacological interventions for target symptoms. R32 used psychotropic medication for a diagnosis of psychosis and would remain free of psychotropic drug related complication through the review date. Staff were to administer psychotropic medications as ordered, monitor for side effects and effectiveness. There was no mention of target symptoms that staff were to	F 758			

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F 758	Continued From page 14 monitor for effectiveness or any identified non-pharmacological interventions for target symptoms. Interview on 2/19/25 at 3:39 p.m., with R32 identified he had been in a state of depression for years and his doctor finally talked him into doing something. He reported at first the medication did not seem to help but then he started to see this mental health person and she started him on some other medications that have worked. He reported he took something for anxiety as he feels anxious inside and he takes another medication because he sees things like mice, rats, raccoons, and cats running around in his room. He stated he knows they are not there, and it was not real, but he still seems them. He reported he also sees people standing or sitting in the chair but mostly sitting he stated he has seen his mother many times and once at 4 am he seen the wound nurse sitting in the chair. He revealed he knew the people were not there, and they did not scare him, but he still seen them. He reported sometimes it is just dark shadows that are standing by me or sitting in the chair. He again stated he sees things running around his room a lot, but he knows there was not raccoons in his room. Interview on 2/19/25 at 3:49 p.m., with registered nurse (RN)-C agreed that R32 had no identified specific target symptoms his medications had been ordered to treat identified anywhere she could see. She agreed it would be hard to determine if the medications were effective or not if staff did not know what they were to be treating. She revealed that R32 did isolated to his room mostly, he did have anxiety related to his health conditions, and he did hallucinate at times where	F 758			

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F 758	Continued From page 15 he has seen people that were not there. Interview on 2/19/25 at 4:18 p.m., with registered nurse (RN)-B an interim consultant confirmed that the psychopharmacological medication assessment had identified diagnosis but no specific target behaviors or symptoms that the medication was ordered to treat. RN-B revealed his expectation was that each psychoactive medication would have identified target symptoms or behaviors and that should be identified on the care plan. Interview on 2/19/25 at 5:11 p.m. with assistant director of nursing (ADON) registered nurse (RN)-A confirmed she was unable to locate any target behaviors or symptoms that R32's medications had been ordered to treat. Interview on 2/19/25 at 5:15 p.m. with director of nursing (DON) confirmed that there should be identified target behaviors or symptoms for each psychoactive medication ordered. She agreed without the identified target behavior or symptom it would be hard to determine if the medication was effective. Review of February 2025, Psychotropic Drug Monitoring policy identified the primary diagnosis or target behavior must be specified with each psychotropic medication order and would be identified on the medication order as well. The resident care plan would identify the goal of the medication, the medication side effect monitoring, target behaviors, the information that would be used to determine the effectiveness of the medication and reported to the physician. Each psychoactive medication ordered would identify a different target behavior that the medication was	F 758			

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F 758	Continued From page 16	F 758			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: 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:	F 761			3/20/25
			F761 Labeling and Storage of Medication DON or RN designee will be lead to ensure all nurses (LPN/RN) will be trained and have proven competency upon hire and annually thereafter. This will include staff nurses and agency nurses no matter what status of employment they are. Staff		

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F 761	Continued From page 17 Observation on 2/18/25 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 2/16/25. There was no discard date labeled on the insulin pen. Observation on 2/18/25 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 250-300= 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 2/18/25 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 151-200= 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	F 761	education completed at staff meetings held on 3/18/25 and 3/20/25 including update on Medication Administration policy, medication rights, and proper labeling and storage of medications including insulin. Medication expiration dating resource tool posted in each medication room as well as medication server cabinet where insulin is stored. Audit of all residents who have insulin orders will be conducted with baseline starting March 2025 with the following schedule: every resident monthly x 3 months if 100% then 6 residents random every month x 3 months if 100% then 6 residents every other month x 3 months and if 100% then 6 residents x 1 quarter if 100% then random spot checks thereafter. Will report at QAPI quarterly audit findings.		

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F 761	Continued From page 18 in R28's medical record. R28's Humalog insulin pen had an open or discard date on the label. Further observation on 2/18/25 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 2/18/25 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 1/15/25 but no discard date and a glargine insulin pen had no open or discard date on the label. Interview on 2/18/25 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 2/18/25 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 2/19/25 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	F 761			

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F 761	Continued From page 19 dates on insulin pens. Review of October 2022 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.	F 761			
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.	F 838			4/28/25

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F 838	Continued From page 20 §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or	F 838			

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F 838	Continued From page 21 training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and	F 838			

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F 838	Continued From page 22 plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: 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	F 838	F838 Facility Assessment - The facility assessment will be updated to reflect the correct staffing hours in accordance in how we staff nurse aides on the weekends. Initial review and updates completed by Administrator and DON. - An updated facility assessment has been drafted and sent to the QAPI Committee. The QAPI Committee will review it on 4-8-2025. The facility assessment will then go to the Board of Directors on 4-28-2025 for final approval. - To ensure future compliance, JMHS will		

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F 838	Continued From page 23 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). 5) 9/28/24 day shift RN-12 hours, LPN/TMA 15 hours, NA 58 hours evening shift -LPN/TMA 12	F 838	continuously review our facility assessment and staffing plans. If there are significant changes needed to the staffing plan, the facility assessment will be updated and brought to the QAPI Committee and the Board to approve.		

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F 838	Continued From page 24 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.	F 838			
F 851 SS=F	There was no additional policy related to staffing provided by the end of the survey. Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or	F 851			3/31/25

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F 851	Continued From page 25 resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.			F 851			

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F 851	Continued From page 26 §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: 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) Casper 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	F 851	F851 Payroll Based Journal - Education with staff was conducted on 3/18/25 and 3/20/25 to ensure they understand how to properly clock in and out of the departments correctly. The Scheduling Coordinator will review and compare the time sheets to the schedule to ensure accuracy before each bi-weekly payroll submission. - The Payroll Coordinator will do a review with Administrator, DON, or Scheduling Coordinator prior to future PBJ submission. This review will verify the accuracy of the report prior to submission. - A PBJ reporting policy will be created by 3-31-2025 which will include responsibilities, reporting process, and verification process.		

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F 851	Continued From page 27 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.	F 851			
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced	F 882			3/20/25

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F 882	Continued From page 28 by: 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	F 882	F882 Infection Preventionist Qualifications-Role Plan of correction for I.C staff surveillance of illness: - Updated the Teams illness log to include all information necessary - Re-education email sent to management team 2/21/2025 - Re-education also given to the management team at the managers meeting on 2/27/2025 - Re-education given to nursing home staff at the nursing home staff meeting on 3/18/2025 and 3/20/2025. - Will audit monthly missing Return to work dates for 9 mos. or compliance is obtained. - Baseline: 34% missing Return to work date (facility-wide) - Follow up and document for missing information/re-education as needed. - Reminder email sent to management monthly to update spreadsheet (current) - This information will be shared at QAPI and Management meetings as required - The Infection Preventionist is responsible for the oversight of this along with support from the CEO/Administrator.		

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F 882	Continued From page 29 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. 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	F 882			

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F 882	Continued From page 30 comprehensively.	F 882			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/19/2025. At the time of this survey, Johnson Memorial Hospital & Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/20/2025

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Johnson Memorial Hospital and Home is a one-story building with a partial basement under the "A" wing. The building was constructed in 2018 and was determined to be of Type V (111) construction. The building is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors, which is monitored for automatic fire	K 000			

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K 000	Continued From page 2 department notification. The building is separated from the adjacent hospital and assisted living by 2-hour fire barriers and is separated into smoke compartments by two 2 hour fire barriers and three smoke barriers. The facility has a capacity of 56 beds and had a census of 55 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K 000			
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress per NFPA 101 (2012 edition), Life Safety Code, sections 18.2.1, and 7.1.10.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 02/19/2025 between 9:30 AM and 12:00 PM, it was revealed by observation that egress door 6 was difficult to open due to the threshold preventing the door from opening without using			K 211	K211 Means of Egress ☐ General 1. The threshold of door 6 was taken out and metal ribbing was ground off of the bottom to create more clearance. 2. The maintenance staff will conduct monthly audits to ensure all emergency exit doors open without any resistance. 3. A spreadsheet will be created to document the results of the monthly audits. If doors fail, they will require immediate action to correct the fault. 4. Scott Ochsendorf, Facilities Manager, is responsible for the implementation of		2/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245485	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER JOHNSON MEMORIAL HOSP & HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1290 LOCUST STREET DAWSON, MN 56232		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 211	Continued From page 3 excessive force. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	the plan of correction of this deficiency. 5. The correction was completed on 2/20/2025. Dan Buchholz, DSFM, inspected this door on 2/26/2025 when he was onsite for our hospital survey.		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(5), and 5.2.1.2. These deficient findings could have a patterned impact on residents within the facility.	K 353		2/20/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245485	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER JOHNSON MEMORIAL HOSP & HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1290 LOCUST STREET DAWSON, MN 56232		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 353	Continued From page 4 Findings include: 1. On 02/19/2025 between 9:30 AM and 12:00 PM, it was revealed by observation that items on a storage rack in the dishwashing room of the kitchen were within 18 inches of the sprinkler head. Violation was corrected at the time of discovery. 2. On 02/19/2025 between 9:30 AM and 12:00 PM, it was revealed by observation that several sprinkler heads in the main kitchen and dish room were covered with dust and lint. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	be added to the monthly cleaning tasks that the custodian does in the kitchen. 3. A spreadsheet will be created to track the monthly cleaning of the sprinkler heads, air supply, and return vents. This will also be added to a monthly calendar that will have popup reminders when cleaning is due. 4. Scott Ochsendorf, Facilities Manager, is responsible for the implementation of the plan of correction of this deficiency. 5. The correction was completed on 2/20/2025.		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1-3/4 inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8	K 374		2/20/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245485	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER JOHNSON MEMORIAL HOSP & HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1290 LOCUST STREET DAWSON, MN 56232		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 374	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.7.8 and 8.5.4.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 02/19/2025 between 9:30 AM and 12:00 PM, it was revealed by observation that the fire barrier door between the Care Center and the hospital did not close completely leaving a gap between the door leaves. 2. On 02/19/2025 between 9:30 AM and 12:00 PM, it was revealed by observation that the smoke barrier door by the staff lounge did not close completely leaving a gap between the two door leaves. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	K374 Subdivision of Building Spaces ☐ Smoke Barrier 1. The doors and the door closers were adjusted so the doors closed completely on their own. 2. The maintenance staff will conduct monthly audits to ensure that all fire/smoke barrier doors completely close on their own. 3. A spreadsheet will be created to document the results of the monthly audits. If doors fail, they will require immediate action to correct the fault. 4. Scott Ochsendorf, Facilities Manager, is responsible for the implementation of the plan of correction of this deficiency. 5. The correction was completed on 2/20/2025. Dan Buchholz, DSFM, inspected this door on 2/26/2025 when he was onsite for our hospital survey.		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245485	MULTIPLE CONSTRUCTION A. BUILDING: 02 - NEW BUILDING B. WING _____	DATE SURVEY COMPLETE: 2/19/2025
NAME OF PROVIDER OR SUPPLIER JOHNSON MEMORIAL HOSP & HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1290 LOCUST STREET DAWSON, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.1.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 70, (2011 edition), National Electrical Code, section 400.8(1). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/19/2025 between 9:30 AM and 12:00 PM, it was revealed observation that an extension cord was being used to supply power to a Christmas tree in room 13. Violation was corrected at the time of discovery. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			

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

The above isolated deficiencies pose no actual harm to the residents



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 1, 2025

Administrator
Johnson Memorial Hosp & Home
1290 Locust Street
Dawson, MN 56232

RE: CCN: 245485
Cycle Start Date: February 20, 2025

Dear Administrator:

On April 30, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112