STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	59168	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME ALC	801 SOUTH MAIN ST POST OFFICE BOX 195 ROSLYN, SD 57261

(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) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 5/5/25 through 5/8/25. Strand-Kjorsvig Community Rest Home ALC was found not in compliance with the following requirements: S282, S296, S305, S331, S352, S450, S506, and S642.	S 000		
S 282	44:70:04:02 Administrator The administrator or designee must be available to meet the needs of the residents or to meet with a resident and family when needed. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, observation, record review, policy review, and job description review the provider failed to ensure the facility was operated under the supervision of administrator A to ensure quality management and the overall well-being of all 26 residents in the facility. Findings include: 1. Interview on 5/6/25 at 4:35 p.m. with administrator A regarding his schedule revealed: *He tried to be in the building weekly. *If he was unavailable, administrator B would be in the building once a week. *Administrator B started coming to the building once a week in January 2025. *Director of nursing (DON) C, business manager (BM) O, and dietary manger E were to be in the building on a full-time basis. 2. Interview on 5/7/25 at 9:59 a.m. with	S 282	Assistant director of nursing has been hired to assist in additional duties. Refer to plan of corrections for tags S282, S296, S305, S331, S352, S450, S506, S642.	6/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Samuel Van Voorst
TITLE: Administrator
(X6) DATE: 6/9/25

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S 282	Continued From page 1	S 282		

administrator B regarding department managers' time in the building revealed:
*She did not know administrator A's schedule.
*She was the full-time administrator for Dell Rapids Care and Rehab Center.
*If administrator A was unavailable, she would be in the building one day a week.
*She started coming to the building on a weekly basis in January 2025 to help implement a new quality improvement plan.
*The maintenance supervisor worked 10 hours a week and was on-call.
*The minimum data set (MDS) coordinator worked in the facility on Mondays and Tuesdays and would work remotely after that.

3. Interview on 5/8/25 at 9:04 a.m. with licensed practical nurse (LPN)/social services designee (SSD) D regarding her schedule revealed:
*She normally worked on Mondays and Thursdays as the SSD.
*She would also fill in as a charge nurse when needed.
*If a new resident admission was scheduled for a different day, she worked it out with DON C to cover the admission process.

4. Interview on 5/8/25 at 10:23 a.m. with administrator A regarding the day-to-day operations of the facility revealed:
*He was the administrator of record for the facility.
*DON C and BM O addressed most of the day-to-day activities in the building.
*If there was an issue they could not address, they contacted administrator A or administrator B.
*Administrator A or administrator B would come to the building and address the situation that day.
*He agreed there were a lot of management issues delegated to DON C and BM O to ensure

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S 282	Continued From page 2	S 282		

resident services were being provided and the regulation requirements were being met.

5. Interview on 5/8/25 at 11:44 a.m. with DON C regarding administrative oversight revealed:
*Most of the facility's administrative duties fell upon her and BM O.
*She stated she struggled to do her job as the DON while covering for other departments, including administration.
*She would address issues in other departments, which took time away from completion of her director of nursing responsibilities.
*If she had a major issue, she would call or email administrator A.
*Administrator A's response time was not always timely.
*Her responsibility of over-seeing the quality assurance meetings were turned over to administrator B as of 5/5/25 to lighten her work load.

BM O was out of the office during the survey and unavailable for an interview.

Review of the provider's undated Administrator job description revealed:
*"The primary purpose of your job is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents."
*"As the Administrator, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties."
*"Every effort has been made to identify the essential functions of this position. However, it in no way states or implies that these are the only

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S 282	Continued From page 3 duties you will be required to perform. The omission of specific statements of duties does not exclude them from the position if the work is similar, related, or is an essential function of the position." *"Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities." *"Ensure that all employees, residents, visitors, and the general public follow established policies and procedures." *"Assume the administrative authority, responsibility and accountability of directing the activities and programs of the facility." *"Assist the Infection Control Coordinator, and/or Committee, in identifying, evaluating, and classifying routine and job-related functions to ensure that tasks involving potential exposure to blood/body fluids are properly identified and recorded." *"Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies." Refer to S296, S305, S331, S352, S450, S506, S630, and S642.	S 282		
S 296	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures;	S 296		

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S 296	Continued From page 4 (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8). This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel records review, training transcript review, and interview, the provider failed to ensure training was completed on all the required topics for: *Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms for five of five sampled employees (F, G, H, I, and J) within 30 days of hire and annually. *Advance directives for two of five sampled employees (I and J) within 30 days of hire. Findings include:	S 296	Unable to correct noncompliance on initial staff training. Personnel training process for new employees will be reviewed and revised as needed and all staff responsible for new employee training will be re-educated for correct compliance by 6/22/25. Business Office manager or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for 2 months. Business office manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advised to discontinue monitoring.	6/22/25

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S 296	Continued From page 5 1. Review of employee personnel records revealed: *Employee F was hired on 12/15/23. *Employee G was hired on 1/15/25. *Employee H was hired on 1/6/25. *Employee I was hired on 7/10/24. *Employee J was hired on 10/31/24. 2. Review of employee training records and online training transcripts revealed: *There was no documentation that employees F, G, H, I, and J had received training on incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. *There was no documentation that employee I had received training on advance directives. *Employee J received training on advance directives on 1/30/25. -That was three months after she was hired. 3. Interview on 5/8/25 at 7:34 a.m. with director of nursing (DON) C and administrator B revealed: *The provider used an online training program for employee-required training. *DON C confirmed employees F, G, H, I, and J had not completed training on incidents and diseases subject to mandatory reporting and the facility's reporting. -She had been unaware that those were required training topics. *They confirmed employee J had not received training topics on advanced directives within 30 days of hire. *Administrator B was unaware that the above trainings had not been completed. -She expected orientation and annual training to be completed within the required time frame. A staff education policy was requested on 5/7/25 at 4:35 p.m. and had not been provided before	S 296		

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S 296	Continued From page 6 the survey exit.	S 296		
S 305	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee records review, interview, and policy review, the provider failed to ensure one of five sampled employees (J) was evaluated by a licensed health professional within 14 days from their start of employment. Findings include: 1. Review of licensed practical nurse J's employee records revealed: *She was hired on 10/31/24. *There was no documentation that a health evaluation had been completed. 2. Interview on 5/8/25 at 7:34 a.m. with director of nursing (DON) C revealed: *She would complete the employee health evaluation on the employee's first working shift. *If she were unavailable to complete the employee's health evaluation, she would assign that task to the charge nurse on duty. *She was unable to locate documentation that employee J's health evaluation had been completed. -She thought it may have been filed incorrectly.	S 305	Unable to correct noncompliance of health evaluation within 14 days of hire. The health evaluation policy will be reviewed and revised as needed and all staff responsible for new hires will be re-educated on correct process for compliance by 6/22/25. DON or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for 2 months. DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	6/22/25

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S 305	Continued From page 7 A health evaluation policy was requested on 5/8/25 at 7:30 a.m. and had not been provided before the survey exit.	S 305		
S 331	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: (1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the	S 331	Unable to correct noncompliance of TB screening within 21 days of hire. The tuberculosis policy will be reviewed and revised as needed and all staff responsible for new hires will be re-educated on correct process for compliance by 6/22/25. Business office manager or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for 2 months. Business office manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	6/22/25

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S 331	Continued From page 8 presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on employee records review, interview, and policy review, the provider failed to ensure one of five sampled employees (J) had received the two-step tuberculin (TB) skin test within twenty-one days of their employment. Findings include: 1. Review of licensed practical nurse J's employee records revealed: *She was hired on 10/31/24. *The documentation in her record revealed she had received the TB skin test on 12/2/24 and 12/27/24. -This was outside of the twenty-one day requirement. 2. Interview on 5/8/25 at 7:34 a.m. with director of nursing (DON) C revealed: *She completed the employee TB screening skin test on the employee's first working shift. *If she were unable to complete the employee's TB screening skin test, she would assign that task to the charge nurse on duty. *She was unsure why the above-listed TB screening skin test had been completed late. Review of the providers' revised February 2025 Infection Control and Prevention policy revealed: *"A two-step TB skin test will be completed on all staff members within 21 days of hire unless there is documentation of a two-step results within the past year."	S 331		

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S 352	Continued From page 9	S 352		
S 352	44:70:04:13 Resident Admissions The facility shall evaluate and document each resident's care needs at the time of admission, thirty days after admission, and annually thereafter, to determine if the facility can meet the needs for each resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to evaluate and document the care needs for: *One of three sampled residents (1) at admission. *Three of three sampled residents (1, 2, and 4) thirty days after their admission. *One of three sampled residents (4) annually. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted on 3/18/25. *An admission and thirty-day evaluation of the resident's care needs were not documented in his record. 2. Review of resident 2's EMR revealed: *She was admitted on 11/18/24. *Her admission evaluation of care needs was completed on 11/18/24. *A thirty-day evaluation of the resident's care needs was not documented in her record. 3. Review of resident 3's EMR revealed. *He was admitted on 10/9/23. *His admission evaluation of care needs was completed on 10//10/23. *A thirty-day and annual evaluation of the	S 352	Unable to correct past noncompliance to evaluation and documentation on residents on admission, 30 days after admission, and annually. Process in place going forward. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. ADON or designee will audit ALC evaluations and documentation on admission, 30 days after admission, and annual assessments weekly for 4 weeks and monthly for 4 months additional months or longer as determined by audit results. ADON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

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S 352	Continued From page 10 resident's care needs were not documented in his record. 4. Interview on 5/7/25 at 8:30 a.m. with director of nursing (DON) C regarding evaluation of resident care needs revealed: *She was responsible for completing the resident evaluation of needs. *Her understanding was they only needed to be completed upon admission. *She was not aware thirty-day and annual evaluations needed to be completed. *She confirmed she had missed the admission evaluation for resident 1. 5. Interview on 5/7/25 at 9:30 a.m. with administrator B regarding resident evaluation of needs revealed: *DON C was responsible for completing the evaluations. *She expected the evaluations to be completed according to their policy. *She confirmed the evaluations were not completed. 6. A policy for evaluation of care needs was requested on 5/7/25 at 9:15 a.m. DON C stated there was no policy for those evaluations.	S 352		
S 450	44:70:06:01 Dietetic Services The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of § 44:70:02:06. This Administrative Rule of South Dakota is not	S 450		

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S 450	Continued From page 11 met as evidenced by: Based on observation, interview, and policy review the provider failed to follow acceptable food safety practices by not having ensured that food packages were dated when opened and outdated food items were discarded from inventory in one of one observed kitchen. Findings include: 1. Observation on 5/5/25 at 1:03 p.m. of the dry food storage room revealed: *One opened container of Rice Crispies cereal with no date on it. *One opened container of Raisin Bran cereal with no date on it. 2. Observation on 5/5/25 at 1:27 p.m. of the walk-in refrigerator revealed: *One carton of Vanilla Boost Glucose Control supplement with a use-by date of January 3, 2025. *One opened package of shredded low moisture mozzarella cheese with a best by date of April 19, 2025. *The mozzarella cheese had condensed into quarter-sized balls of cheese. 3. Interview on 5/5/25 at 1:34 p.m. with dietary manager E regarding opened and expired food items revealed: *He was not aware of the unmarked opened food containers or the outdated food items. *It was his expectation that containers of food would be dated when opened, and food items would be used or discarded before the use-by date. *His expectation was that all dietary staff would monitor food items for food items that were past the use by date or expired. *He checked used by dates when the weekly food	S 450	All expired food items were immediately removed from the kitchen. Dietary staff will be educated on ensuring food items are dated when opening and outdated items being discarded with documentation by 6/22/25. Administrator, dietary manager, and interdisciplinary team will review and revise policies and procedures as necessary. Dietary manager or designee will audit food labels and expired food weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. Dietary manager or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

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S 450	Continued From page 12 truck delivery arrived. 4. Review of the provider's 5/5/25 revised Expired Food policy revealed: *"Food products will be inspected on a regular basis to ensure that any products that are expired or near expiration will be identified and reported to the DM for further instructions." *"All products will be inspected weekly by Dietary Personnel on Wednesday before the arrival of the food truck." *"All items that are expired will be labeled (Do not use/Do not discard)." *"All staff must follow FIFO (First In First Out) and inspect the expiration date on all products that are needed for use before they are used in the operation." Review of the provider's 10/20/24 revised Storage of food opened in the storeroom or preparation area policy revealed: *"To make sure all items that are opened in the storeroom or main production area are covered, labeled and dated properly." *"1. Date the container when opened." *"2. Reseal the container." *"3. If the container cannot be resealed, you can place it in a Tupperware container with a tight lid and/or a zip lock bag if possible. Label and date the product."	S 450		
S 506	44:70:06:17 Required Dietary Inservice Training The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all healthcare personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for any dietary or food-handling personnel and	S 506		

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S 506	Continued From page 13 must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel records review, training transcript review, and interview, the provider failed to ensure training was completed on eight of the nine required dietary training topics for food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, and sanitation requirements for one of five sampled dietary staff members (K). Findings include: 1. Review of employee personnel records revealed that dietary employee K was hired on 2/20/25 as a "waiter." 2. Review of employee K's online training transcripts revealed there was no documentation that employee K had received training on food safety, handwashing, food handling and preparation techniques, food-borne illnesses,	S 506	Unable to correct noncompliance of providing complete training to dietary staff member K. Dietary staff K will be educated on all dietary topics. Dietary training process for new employees will be reviewed and revised as needed and all staff responsible for new employee training will be re-educated for correct compliance by 6/22/25. Dietary manager or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for 2 months. Dietary manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	6/22/25

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S 506	Continued From page 14 serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, or sanitation. 3. Interview on 5/8/25 at 7:34 a.m. with director of nursing (DON) C and administrator B revealed: *The provider used an online training program for employee-required training. *They confirmed there was no documentation to support that employee K had received the required dietary training on food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, or sanitation. *Administrator B was unaware that the above trainings had not been completed. -The training on the above-listed topics was assigned to be completed in May 2025 and had been missed in the initial required orientation training for employee K. -She expected the required orientation training to be completed within the required 30-day time frame of the employee's hire date. *Dietary manager (DM) E was responsible for ensuring that the dietary staff completed their required orientation and annual training. 4. Interview on 5/8/25 at 7:47 a.m. with DM E regarding orientation training for dietary employees revealed: *Business manager (BM) O assigned the training in the online training program. *DM E ensured that dietary staff completed their required training before they worked their first shift. *DM E was unaware that employee K had not completed training on the above-listed topics.	S 506		

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S 506	Continued From page 15 A staff education policy was requested on 5/7/25 at 4:35 p.m. and had not been provided before the survey exit.	S 506		
S 642	44:70:07:05 Control And Accountability of Medications The facility must receive written authorization from the resident's physician, physician assistant, or nurse practitioner before releasing any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication must be documented in the resident's record, indicating quantity, drug name, and strength. The facility shall maintain records that account for all medications and drugs from receipt through administration, destruction, or return. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to follow their policies for controlled medications (medications with risk for abuse, addiction, and potential theft) to ensure accurate counts and complete documentation of those medications in one of one medication cart and one of one refrigerators that contained controlled medications. Findings include: 1. Observation and interview with licensed practical nurse (LPN) F on 5/6/25 at 9:40 a.m. of a binder labeled "Narcotic Binder" on the east medication cart revealed: *A form in the front of the binder was labeled	S 642	Unable to correct past noncompliance of accurate counts with documentation on medication cart and refrigerator. Nurses will be educated on accurate counting and documentation with documentation buy 6/22/25. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. Activity Coordinator or designee will audit medication cart and fridge counts weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. Activity Coordinator or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

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"Control E-Kit [emergency kit for controlled medications] Shift Count".
*The area for the month and year o that form was blank.
-LPN F verified that form was for May 2025.
*That Control E-Kit Shift Count form had six medications identified on it:
-"Tramadol [a pain medication] 50 mg [milligrams] PO [by mouth]".
-"Oxycodone [a pain medication] 2.5 mg tab PO".
-Morphine [a pain medication] 10 mg/0.5 ml [milliliters] PO/SL [sublingual]" .
-"Hydrocodone/APAP [a pain medication] 5/325 mg PO".
-"Lorazepam[an antianxiety medication] 0.5 mg PO" .
-"Lorazepam 2 mg/ml IM/IV [intermuscular/intravenous]".
*That Control E-Kit Shift Count form had locations to document for each day of the month for both day and night counts that included:
-The number of pills or syringes counted.
-The initials of the persons that counted those medications with an indicator that there was to be two persons.
*The Controlled E-Kit Shift Count form documentation indicated:
-On 5/1/25 there was no second staff's initials for the day count and no count or initials for the night count.
-On 5/2/25 no documentation was completed.
-On 5/3/25 there was no count or initials for the day count, and no second staff's initials for the night count.
-5/5/25 there was one missing initial for the night count.
*Another form labeled "Narcotic E-Kit Numbers" was in the narcotic binder.
-That form had areas for each day to document two staff's signatures for the "First Shift" and

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S 642	Continued From page 17 "Second Shift" and a number on the E-Kit lock tags for the "Gray Cupboard E-Kit", the "East Narc [narcotic] Drawer E-Kit", and the "Fridge E-Kit". -On 5/2/25 there were no numbers documented in the three columns and the second shift only had one signature documented. 2. Interview on 5/6/25 at 9:50 a.m. with LPN F revealed: *The Controlled E-Kit shift count form was how the staff documented the counts emergency supply of controlled medications. *The controlled medications were to be counted at the change of shift by the oncoming and outgoing staff to verify the medications counts were accurate. *Each one of the three different emergency medication kits were sealed with a numbered tag. *The Narcotic E-Kit Form was where the tag numbers on each kit were documented to be sure no had broken the tag and accessed the kit without prior authorization from the pharmacy to remove a medication for administration to a resident. *The numbers on the identified tags were to be checked and documented at change of shift by two staff members on the Narcotic E-Kit Numbers form. *LPN F verified there was incomplete documentation on both forms for May 2025. *LPN F stated the controlled substances prescribed to individual resident were sent from pharmacy in a bubble pack medication card system and stored in a locked drawer in each medication cart. *The individual residents'-controlled medications were counted at each change of shift but there was no form to document that count had occurred for those medications.	S 642		

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S 642	Continued From page 18 3. Interview on 5/6/25 at 10:22 a.m. with LPN I revealed: *The controlled medication counts were to be completed on the E-Kits and for each resident that was prescribed a controlled medication at the change of each shift by two nursing staff members authorized to administer medications. *The E-Kit controlled substances were stored in the east medication cart within the locked drawer and in a locked compartment in the refrigerator. *The signatures on the forms were to indicate that the controlled medication counts were completed and accurate and the tags were checked and found to be in place and the tag numbers were accurate. *There was no location to document the individual residents' controlled medications counts had been completed or who completed those counts to verify the accuracy of the amount of those medications present. 4. Review of April 2025 Control E-Kit Shift Count form revealed: *The day counts did not have documentation of the second staff member's initials ten times. *The night counts did not have documentation of the second staff member's initials nine times. Review of March 2025 Control E-Kit Shift Count form revealed: *The day count was missing documentation of the count on 3/17/25 and did not have documentation of the second staff member's initials nine times. *The night counts did not have documentation of the second staff member's initials seven times. Review of February 2025 Control E-Kit Shift Count revealed: *The day count was missing documentation of the	S 642		

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count two times and did not have documentation of the second staff member's initials seven times.
*The night count was missing documentation of the count two times and did not have documentation of the second staff member's initials five times.

Review of January 2025 Control E-Kit Shift Count revealed:
*The day count was missing documentation of the count five times and did not have documentation of the second staff member's initials eleven times.
*The night count was missing documentation of the count three times and did not have documentation of the second staff member's initials thirteen times.

Review of December 2024 Control E-Kit Shift Count revealed:
*The day count was missing documentation of the count seven times and did not have documentation of the second staff member's initials nine times.
*The night count was missing documentation of the count five times and did not have documentation of the second staff member's initials twelve times.

5. Review of April 2025 Narcotic E-Kit Numbers revealed:
*On 4/3/25 no tag number were documented and one signature documented for the first shift and the second shift.
*On 4/29/25 no tag numbers were documented.
*Only one signature was documented for either the first or the second shift seven.

6. Interview on 5/8/25 at 11:30 a.m. with director of nursing (DON) C revealed:

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S 642	Continued From page 20 *It was her expectation that all controlled medications were to be counted by two licensed staff members or certified medication aides (CMA) at every change of shift. *The counts were to be documented on the Control E-Kit Shift Count in the front of the narcotic binder. *The signatures on the document would indicate the controlled medication counts had been completed and the counts were accurate. *The tag numbers were to be verified and documented as accurate by two staff members, and she expected that to have been completed at the same time the controlled medications were counted. *She was aware there was no location to document the counts were completed and by which staff members for the residents' controlled medications. -She did not feel that there needed to be a form to document that. The staff were to complete the counts at the change of shifts and were to notify her if there was a discrepancy. *She verified without the documentation of the counts of the residents' controlled medications she would not be able to determine who or when the last count had been completed. *She was not aware of the frequency of missing or incomplete documentation on the Control E-Kit Shift Count forms or the Narcotic E-Kit tag numbers. 7. Review of the provider's 11/5/15 Storage of Facility E-Kit Documentation policy revealed "Emergency controlled substances [medications] must be stored in a double lock system and verified shift to shift". Review of the provider's 12/1/15 Emergency Kits policy revealed "A Control E-Kit Shift Count will be	S 642		

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S 642	Continued From page 21 used by facility staff to keep track and use for counting controlled case medications shift to shift on a monthly basis." Review of the provider's undated Narcotic Count policy revealed: *"Narcotics [controlled medications] will be counted by licensed nursing personnel to assure they are properly accounted for at the beginning and ending of each shift." *"The on-going and off-going nurse at shift change will perform a physical count of the narcotic drawer." *"Each nurse will sign the narcotic count sheet when the count is completed." Review of the provider's November 2017 Controlled Medication Storage policy revealed: *"At each shift change or when keys are surrendered, a physical inventory of all Schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report." *"Current controlled medication accountability records are kept in the MAR [medication administration record] or narcotic book."	S 642		