STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. BUILDING _____ B. WING _____	C 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAM'S CARE CENTER	103 N VIOLA ST MILBANK, SD 57252

(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
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/22/24 through 7/24/24. Areas surveyed included resident neglect related to wound care, resident abuse related to allegations of abuse from a staff member, drug accountability related to a missing narcotic medication, and misappropriation of resident property. St William's Care Center was found not in compliance with the following requirements: F600, F609, F610, F761, and Past non-compliance at F602.	F 000	For residents 2, 3, and 4; During survey, an online report was submitted to the DOH for the allegation involving resident 4. Resident 3 online report completed 8/8/24, Adult Protective Services 8/13/24and resident 2 report completed prior to survey. ADDENDUM dated 8/14/24: CNA J was suspended 7/19/24, and did not return to work. Status is termination. RT. Identification of other potential residents: The Social Service Designee is asking the resident if they feel safe in the facility, and for those residents with cognitive decline, the family is asked. Supervisors/department heads are asking staff if any abuse/neglect/exploitation has been noted since survey. Once identified, these will be acted upon by reporting through the DH reporting portal. Inquires with the residents and families will continue with MDS assessment timelines by the SSD and will be monitored and reported at QAPI on a quarterly basis for the next 6 months.	8/16/24
F 600 SS=H	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, observation, record review, and policy review, the provider failed to protect three of five sampled residents (2, 3, and 4) from	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rene' Thrift	Administrator	8/14/2024

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 600	Continued From page 1 mistreatment, intimidation, verbal abuse, and physical abuse by one of one certified nurse assistant (J). Findings include: 1. Review of the provider's FRI online report submitted to the SD DOH on 6/30/24 revealed: *Resident 2 was not feeling well on the evening of 6/29/24. She had vomited several times. *Certified nurse assistant (CNA) J was seen by another CNA to have been getting frustrated with resident 2, told resident 2 to "shut up," and swatted resident 2's hands away from her incontinence brief. *CNA J was interviewed about the situation and CNA J denied saying "shut up" to the resident and swatting the resident's hands. *She was assigned educational videos to watch about coping skills, how to calm down in difficult caregiving situations, anger management, and people living with dementia. *CNA J "was allowed to return to work after her time of suspension, completing the information noted above, and signing a performance improvement plan." 2. Observation and interview on 7/22/24 at 4:18 p.m. with resident 2 revealed: *She was appropriately dressed and sitting in her wheelchair in her room. *Her call light and teddy bear were on the floor at her feet, and her lap blanket appeared to have been pushed away slightly. *She was watching a show on the television. *She repeated "I'm lost" multiple times. *Her room was clean and free from clutter. *Surveyor picked up the call light from the floor and gave it to resident 2. She was able to understand the purpose of the button. *She pressed the button.	F 600	Regularly scheduled full time and part time (and PRN if working) staff will be instructed on Abuse, Neglect, and Exploitation through a directed inservice, beginning 8/12/24. Any PRN staff who did not attend will be trained prior to next shift scheduled. Education/training will include all licensed and unlicensed staff and their role and responsibility for action against allegations of abuse. The Abuse/Neglect/Misappropriation of Resident Property Policy was updated to reflect these changes Under "Policy" a statement added: There is a zero tolerance for abuse at St. William's Care Center. Each staff member is a mandatory reporter for the state of SD. Under "Procedure" --The responsibility for carrying out this plan lies with all the staff employed by St. William's Care Center. The Administrator, DON, ADON, Management Team, member of the Investigative Team, Board of Directors, and the Medical Director will oversee the policy and its implementation and enforcement. Under "Training"--Staff will be instructed to use the phrase "I am reporting" or "I have an allegation" when reporting to the nurse or supervisory staff an allegation so there is no misunderstanding of intent to report.	

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F 600	Continued From page 2 3. Observation on 7/22/24 at 4:32 p.m. with CNA P revealed: *She answered resident 2's call light. *Resident 2 was not able to verbalize any needs. -She repeated, "I'm lost." *CNA P calmly reminded her that she was safe, her family knew where she was, she was in the nursing home, and that supper was soon. *Resident 2 calmed down and continued to watch her show. Interview at that time with CNA P revealed: *It was normal for resident 2 to repeat the same phrase. *She was taught to calmly remind the resident about where she was at and address any of her needs. *She was not aware of any recent allegations of staff having been rough or rude to resident 2. 4. Interview on 7/22/24 at 4:37 p.m. with resident 12 and at 5:05 p.m. with resident 13 revealed that neither of them had any concerns with their safety. They both felt free from abuse and neglect. 5. Interviews on 7/23/24 from 11:00 a.m. to 12:55 p.m. with residents 5, 6, 7, and 8 about feelings of safety revealed they all expressed positive feelings of living at that facility, and they had no concerns regarding their safety. 6. Interviews on 7/23/24 at 1:20 p.m. with CNA F and at 4:05 p.m. with CNA G regarding how staff treated residents revealed: *CNA F denied that she had witnessed any staff member mistreating a resident verbally or physically.	F 600	Under "Process" --Nursing staff have been instructed on methods to do the initial reporting of such incidents. --A team of investigators from SWCC will conduct a thorough investigation to include supervisory staff, nurses, administrator, DON, ADON, or other designated personnel. All staff present in the area, or involved in the incident will be interviewed to ensure all facts considered. --If the allegation involves another resident, or family member the victim will be protected from them as instructed by staff making the report. --Report will be made immediately to the nurse, or supervisory staff. If reported to the supervisory staff, that staff will need to inform the nurse who will complete the initial report and make contacts as designated These steps were added specific to reporting at the facility: Once an allegation has been identified, the first and foremost action will be to ensure the resident is safe. This may be done by removing the victim to another area or removing the alleged perpetrator from the area. Either way, the separation will keep further incidents from happening.	

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F 600	Continued From page 3 *CNA G indicated she had no concerns about resident safety or how residents were treated by other staff members. 7. Interview on 7/23/24 at 1:42 p.m. with CNA L about reporting alleged violations revealed: *She was able to verbalize the correct reporting procedures. *She had not reported any incidents recently. *She was not aware of the situation with resident 2. *There were two incidents that she knew a different CNA reported last week. -Both incidents involved CNA J. -One incident involved resident 3 having been stuck behind a door, and CNA J yelled and banged on that door. -The other incident involved resident 4, but she could not recall the details. -She was not present for either incident but heard about them from a coworker. 8. Observation on 7/23/24 at 1:57 p.m. of resident 3 in her room revealed: *She was resting in bed with her eyes closed. *She was snoring. *Her bed was in a lower position. *There was a fall mat on the floor next to her bed. 9. Observation and interview on 7/23/24 at 1:59 p.m. with resident 4 revealed: *She was laying on her left side on her bed. She was covered by a blanket. *She was able to converse but was saying nonsensical words and was having difficulty expressing herself. 10. Interview on 7/23/24 at 2:36 p.m. with licensed practical nurse (LPN) D revealed:	F 600	System change: New hire staff will receive a training packet including resident rights, mandatory reporting for abuse, neglect or exploitation, and an attestation page to be signed and filed in the HR office. The HR Director will present to QAPI the number of new hires that received training for the 4 months at which time QAPI committee will determine if further monitoring/reporting is needed. Nurses will document inquires of abuse/neglect for each CNA on duty for each nursing shift for the next 30 days and thereafter, Management team will conduct 3 random inquires of abuse/neglect each week for the next 4 months and report findings at to the QAPI committee who will determine if further monitoring is needed. The Administrator or her designee will review the Abuse, Neglect, Misappropriation Policy with QAPI committee for 2 months for any revisions necessary to the process of protecting the victim after which time the QAPI committee will determine if further monitoring is needed. Numbers of allegations of abuse, neglect, and misappropriation will be reviewed with QAPI committee for 2 months at which time it will be determined if further monitoring is needed.	8/16/24

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*She was aware of the incident between CNA J and resident 2, however, she was not there that day.
*She was briefed about the situation.
*She was not aware of any incident where a CNA was banging loudly on a resident's door.

11. Interview on 7/23/24 at 2:44 p.m. with CNA I about the incident between CNA J and resident 2 revealed:
*She confirmed she had worked that day.
*Resident 2 had vomited several times during that shift.
*CNA J was assigned to resident 2 and had called for help with getting her cleaned up and changed.
*A different CNA assisted CNA J, so she did not know all the details.
*She believed the CNA who helped CNA J had a good working relationship with CNA J and would not try to get CNA J in trouble.

12. Interview on 7/23/24 at 2:56 p.m. with nurse aide (NA) M about the incidents involving residents 3 and 4 revealed:
*One incident involved resident 3 and CNA J around supper time approximately two to three weeks ago.
*Resident 3 wheeled herself into her room and closed the door behind her, had gotten her wheelchair stuck, and the staff were not able to open the door.
-She walked by resident 3's room and heard banging. Resident 3 was saying, "Help, I'm stuck."
-She tried to provide verbal directions to resident 3 to maneuver herself away from the door.
-She was not able to open the door.
*NA M was not assigned to resident 3's hallway

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that day, and one of her assigned residents had pressed their call light.
-NA M asked CNA J to assist resident 3 and went to answer her assigned resident's call light.
*She heard CNA J yell and swear loudly at resident 3 to open the door.
-She could not recall what specifically was said.
*She reported that incident to administrator A the same day.
*Another incident happened last Friday, 7/19/24.
-She indicated this incident was "the most concerning" to her and stated it "broke my heart."
*Last week, CNA J became upset with resident 4.
-Resident 4 was at risk for falling and had repeatedly attempted to stand up and walk herself without assistance.
-CNA J wheeled resident 4 out of her room and to the CNA station.
-Resident 4 attempted to stand up from her wheelchair.
-CNA J "forcefully" put her hands on resident 4's shoulders and sat her back down in her wheelchair.
-CNA J said to the staff at the CNA station, "Here, you watch her," and walked away.
*CNA G asked CNA J what was going on and if she was okay.
-CNA J talked loudly back at CNA G in a "rude" manner.
-CNA G requested that CNA J not speak to her in that manner.
-NA M waved at registered nurse (RN) C to get her attention so she could help diffuse the situation.
-NA M volunteered to switch residents with CNA J.
-She reported that incident to administrator A immediately.
*Later that evening, while NA M was helping

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resident 4 get ready for bed, resident 4 was agitated, fidgeting, and repeatedly said, "He's a hateful person. He's a hateful person."
-She asked resident 4, "Who's a hateful person?"
-NA M stated CNA J came into resident 4's room, "[resident 4's] face fell, and she whispered [to NA M], 'Him, he's a hateful person,' and she pointed at [CNA J]."
-NA M again reported her concerns to administrator A that same day.

13. Interview on 7/23/24 at 4:23 p.m. with CNA J about the above incidents revealed:
*She most often as assigned "List A" which included residents 3 and 4.
*Regarding the incident resident 2:
-She felt "really bad" for resident 2 because "she [resident 2] was vomiting a lot."
-She "did what she was trained to do" and cleaned her up, changed her, and repositioned her, and "evidently someone that was working with me thought I told her [resident 2] to shut up. I would never tell a resident to shut up."
-She denied saying "Shut up to the resident."
-She denied swatting the resident's hands.
-She received education after that incident about coping skills and residents with dementia.
*She had worked at that facility for six years.
*If she needed help from another staff member, she would have used the radios to call for help.
-She stated, "Sometimes I feel the other staff ignore me."
*She denied any other reportable incidents.

14. Interview on 7/23/24 at 4:49 p.m. with administrator A regarding the above incidents revealed:
*She confirmed CNA J needed reminders to "Watch her words, her tone."

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*One of the other CNAs came to her "The other day" and told her "[CNA J] is a little cross with the residents."
*She said regarding CNA J, "she doesn't understand dementia."
*After NA M reported the incidents to her the previous week, she texted director of nursing (DON) B.
-DON B had worked a nurse shift that evening.
-She told DON B to "tell [CNA J] she has to watch her interactions."
*Administrator A said, "[CNA J] has a hard time with 'those residents' as in dementia."
*She confirmed she knew about the incident between CNA J and resident 3.
*She initially denied knowledge of the incident between CNA J and resident 4.
-"[CNA J] has had trouble with [resident 4] but I'm not aware of that particular incident."
-However, when detailing the incident further, especially when resident 4 expressed "He's a hateful person," administrator A did remember that incident.
*She kept a daily "log" of conversations she has had throughout the day.
-She could not remember exactly when NA M reported those incidents.

15. Interview on 7/24/24 at 9:33 a.m. with RN C revealed:
*She was currently the staff development coordinator and would resume the DON role when DON B moved.
*She was not aware of any of the incidents regarding CNA J.
*Last Friday (7/19/24), she was at the nurse's station and a CNA flagged her down.
-CNA G and O were "heated because they didn't think CNA J was treating residents the best."

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-She denied hearing the staff yell at each other.
-She denied observing CNA J forcefully sit resident 4 down into her wheelchair.
*She coordinated the monthly staff training day.
*If a CNA needed more experience or training on a particular subject, DON B would have taken care of that as she was directly responsible for the nursing staff.
*She confirmed that CNA J was up to date with the required training topics.

16. Interview on 7/24/24 at 10:28 a.m. with DON B regarding the above incidents revealed:
*She had addressed CNA J's "gestures and facial expressions" with her before as "people with dementia pick up on that."
*She had provided "quite a bit" of informal training to CNA J about her attitude.
*After the incident with resident 2, she provided formal training to CNA J on teamwork.
*Regarding other incidents with CNA J:
-Staff brought up concerns regarding her yelling.
-On 7/19/24, she started her shift at 10:00 p.m. and she spoke with CNA J about her actions. She informed her that was the last warning before termination.
-"Once you bring her [CNA J's] attention to a problem, she fixes it for a while."

17. Interview on 7/24/24 at 11:03 a.m. with administrator A about the above incidents revealed:
*She confirmed she was not informing the other department heads, like RN C the staff development coordinator, about certain incidents in an attempt to maintain confidentiality.
-If an incident involved a CNA, she would have only let DON B know about the situation.
-She had not considered bringing the staff

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development coordinator into the conversation.
*Her investigation process included to:
-Review schedules.
-Interview those staff who were on shift and were involved.
-Speak to each person individually.
-Try to maintain confidentiality.
*She felt the incidents involving CNA J and residents 3 and 4 were probably true because the staff member that reported those incidents was reliable.

18. Interview on 7/24/24 at 12:12 p.m. with CNA K about the incident between resident 2 and CNA J revealed:
*She had worked that day and that resident 2 was not feeling well.
*"It was stressful."
*She helped CNA J with resident 2 as she had vomited multiple times.
*She confirmed she heard CNA J tell the resident to "shut up."
*Later on during that same shift, while she helped CNA J to get resident 2 to bed:
-Resident 2 had been pulling at her incontinence brief.
-She confirmed she saw CNA J swat resident 2's hands and said, "You don't need to be messing with that."
*She was not aware of any other specific incidents involving CNA J.
*"Each shift [CNA J] has some behavioral issues," such as being rude to residents and staff or raising her voice.

19. Review of resident 2's electronic medical record (EMR) revealed:
*On 6/29/24, she vomited and had loose stools that began early in the morning.

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*There was no indication of the 6/29/24 allegations of verbal or physical abuse in the progress notes.
*There was no indication in the progress notes that her family or representative was contacted regarding the alleged verbal or physical abuse on the evening of 6/29/24.
*Her care plan included the following:
-"I was admitted because I need your help and support to manage with these health issues: ...Anxiety disorder...[Unspecified] dementia..."
-"I have the potential to have problems communicating and have problems with my memory because I have Alzheimer's dementia... I show this by having the inability to remember things that happened a short time ago, ...a short attention span, increased disorientation, confusion about time, ...at this time I repeatedly cry out 'help', talk about being 'lost'..."
--"I need my aides to help me the same way every time, tell my nurse about any pain I have, offer me fluids, allow me to wander while assuring me that I am safe/give me directions if I start talking about being 'lost', acknowledge that you understand me, remind me of where I am, keep my items in the same place, face me and speak clearly when talking to me, allow time for me to respond..."
-"I like to be comfortable because I have suspected pain. I show this by having changes in facial expression especially putting shoes on."
--"I need my aides to be extra gentle with me, ask me if I hurt, tell the nurse if I hurt, be patient with me, distract me with conversation."

20. Review of resident 3's care plan revealed:
*"I was admitted because I need your help and support to manage with these health issues: Adult failure to thrive...other symptoms and signs

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involving cognitive functions and awareness, other encephalopathy, unspecified severe protein-calorie malnutrition."
*"I have problems with my memory because I was hospitalized due to failure to thrive, abnormal weight loss, severe protein-calorie malnutrition, psychiatric or mood disorder (depression, anxiety), [hypertension], behaviors. I show this by having a BIMS [Brief Interview for Mental Status] score suggesting severe cognitive impairment, impulsivity, wandering, agitation."
-"I need my aides to help me the same way every time, tell my nurse about any pain I have, offer me fluids, make sure I am active and kept busy, allow me to wander, acknowledge that you understand me, keep my items in the same place, use safety devices...allow time for me to respond...make sure I'm wearing my glasses."
*"I have the potential to feel sad, anxious, I may also experience side effects from my medications because I have a diagnosed mood disorder (depression and anxiety)...have a cognitive impairment, can't move around well, ...take psychotropic medications, ...BIMS suggests severe cognitive impairment, behavioral symptoms, sundowning...
-"When I feel this way I feel down or depressed, can't relax or sleep, may not feel like eating, yell, shout, or scream..."
--"I need my aides to ask me if I'm having pain, offer me a snack or drink, help me call my family, check on me, reassure me, offer me choices, ask me how I'm feeling today, ...help me do as much for myself as I can, record my behaviors..."
*"I like to be comfortable because I sometimes hurt, have arthritis... I show this by [complaints of] pain in my abdomen related to previous bladder cancer and surgery, back pain."
-"I need my aides to ask me if I hurt, tell the nurse

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if I hurt, be patient with me, distract me with conversation, help me to change position."

21. Review of resident 4's EMR revealed:
*She was admitted on 5/31/24.
*She had a pattern of frequently standing up and ambulating without assistance, which resulted in a few falls.
*A "Summary Note" on 6/13/24 read, "Late onset Alzheimer's disease, able to redirect during the day with behaviors but increased agitation during the evening hours. Wears tabs monitor, she will frequently staff, walks with the assist of 2 [staff]. Often strikes out at staff, try to redirect by walking with her the assist of 2, assist her to the bathroom, offer snacks and attempt 1:1 [one to one] sessions. Speech is unclear, can't verbalize needs."
*A "Progress Note" from 6/18/24 read, "...Last evening, she required 1:1 staffing to assure her safety - she repeatedly stood up while holding on to her [wheelchair]. She insists on following a couple staff, but did not seem to tire...Agitated state lasted more than 1.5 hrs [hours] with [1:1] staffing."
*She was experiencing increased agitation on 7/13/24 when she was continually attempting to stand by herself, was resistive to cares, and she was attempting to bite and scratch staff.
*There were no progress notes related to any behaviors or increased agitation on 7/19/24, which was when the alleged physical abuse occurred, and NA M said that resident 4 showed fear and repeated "He's a hateful person."
*There was no indication that her family or representative had been notified regarding the alleged abuse that occurred on 7/19/24.
*Her care plan included the following:
-"I was admitted because I need your help and

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support to manage with these health issues: Alzheimer's disease with late onset, Dementia in other diseases classified elsewhere with mood disturbance, Major depressive disorder..."
-"I have problems communicating, and am forgetful because I have a history of Alzheimer's dementia, do not hear well, emotions affect my ability to communicate, problems with my speech patterns. I show this by having a BIMS that suggests severe impairment, having the inability to recognize people, the inability to remember things that happened a short time ago..."
--"I need my aides to help me the same way every time, tell my nurse about any pain I have, offer me fluids, make sure I am active and kept busy, allow me to wander, acknowledge that you understand me...."
-"I have the potential to feel anxious, angry, sad, confused or forgetful, I may also experience side effects from my medications because I have a diagnosed mood disorder (depression and anxiety), moved here recently, have a hard time carrying on a conversation, have a cognitive impairment..."
--"I need my aides to ask me if I'm having pain, offer me a snack or drink, present tasks to me one at a time, follow my toileting plan, check on me, reassure me, be aware of my stressors..."
-"I need to have someone help me because I am unaware of safety risks... I have the potential to fall down and hurt myself because I have dementia/Alzheimer's disease. In the past I have fallen, and I have a history of getting anxious, upset, or angry (pinch, grab and scratch staff), trying to move around without help..."
--"I need my aides to use a pressure pad in bed, [wheelchair] and recliner; use the following assistive devices to be able to better help me: walker...wheelchair; ...frequently check on me;

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encourage me to use assistance..."

22. Review of CNA J's employee file revealed:
*She started on 4/11/18 and passed all the reference and background checks.
*She was up to date with the required education topics.
*After the allegations against CNA J on 6/29/24, an investigation was initiated.
-Verbal accounts were gathered from resident 2 and all staff on shift at the time of the incident.
-CNA J was suspended from work on 6/30/24 while the investigation was completed.
-She returned to work on 7/1/24.
*An "Employee Performance Improvement and Disciplinary Action Plan - Written Warning" was given to CNA J.
-"Identify problem: Failure to consistently fulfill duties of [a] CNA according to facility standards in a manner that promotes dignity of each person and treating them with respect, consideration and kindness."
-"Standard not being met: allegation of verbal abuse and intimidation of a resident."
-"Employee fails to meet standard for following reasons: On June 29, 2024 there were reported interactions with a resident who was ill... [CNA J] denied yelling 'shut up' to a resident and she denied touching the resident's hands (which was reported as swatted her hands away from the brief)... There is no reason to believe that the party who reported the allegation has anything against [CNA J]. She was told that there have been other instances in which she was guided to lower her volume and/or be attentive to her tone of voice."
-"The allegation made appears to be credible although [CNA J] adamantly denies..."
-There were no signatures or dates anywhere on

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the document.
*DON B followed up with CNA J on each day she worked to audit her actions and behaviors.
-"7/14/24 - I [DON B] worked 6p-10:30p nursing shift: ...[resident 4] tried to bite the nurse after using the bathroom...she was pushing her and pinching her during the shift. [CNA J] was supported in managing/coping with behaviors by DON. She gave evidence of her frustration (body language and facial expression) and was reminded about people with dementia being able to pick up on such things..."
-"7/15/24 - [Resident 3] [was] very busy during the shift...trying to get up without assistance multiple times; She said that [resident 3] was yelling out and this makes her frustrated. She was reminded about coping techniques including working as a team."
-"7/19/24 - [Resident 3] was yelling at others... [CNA J] was observed to be tense, but admitted that other than trying to make sure [resident 3] is safe, there is not a lot to do that is effective in redirecting her when she is like this."
-"7/20/24 - Soke with [CNA J] about concerns from co-workers being impatient and loud when giving directions/guidance with behavioral issues."
*The provider had a system where "progress notes" could be submitted associated with each employee:
-"7/20/24: concerns about quality of care - the administrator has heard concerns from [CNA J's] co-workers about her being impatient and being loud in giving guidance/intervening in behavioral issues. [CNA J] was counseled about the need to be attentive to how her actions and verbalizations are being interpreted. She was told that with her last warning, it was noted that if there would be an allegation that is anything other than

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unsubstantiated, this would result in termination of employment."
-"6/6/24: ...At times, when a resident is particularly agitated, you might need reminders to speak at a lower volume and to remember 'Q-TIP' (quit taking it personally)."
-"6/6/23: Other CNA came walking by the desk with a resident and said that she voided in another resident's closet. While that CNA took the resident to get cleaned up, [CNA J] was asked by the nurse to 'Please go clean the urine up out of that resident's room, because housekeeping is out of the building and said resident has family in their room' Instead of doing what was asked of her she went into another resident's room, not cleaning up the mess. Staff finally emerged from the other resident's room once she heard that the urine was cleaned up by someone else."
-"10/12/21: concerns about quality of care...received report that [CNA J] spoke very harshly to a resident in dining room. Spoke to another resident who reported the issue...Spoke to [CNA J] about this witnessed behavior, she informed me that she had already spoken to [administrator A]...discussed what resident reported (CNA yelling at resident across room in dining room)...discussed better ways to handle the situation instead of yelling at resident...discussed understanding the perception of someone watching what was occurring and how it may have looked to them...discussed walking across the room and speaking discreetly to a resident, not yelling from across the room."
-"6/29/21: spoken to concerning some reported incident of saying 'shut up' to resident, [CNA J] denies this happening, also reminded not to speak about personal things in front of residents when taking care of them."
-"5/13/19: resident came back from living room

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[at 2:30 p.m.] requesting to use the bathroom; [CNA J] said ok and walked the opposite way; 15 minutes later writer found [CNA J] in cafeteria eating a donut; writer stated '[resident] needs to use the bathroom,' [CNA J] said 'I'm going.'"

23. Review of the provider's 7/19/24 updated Abuse, Neglect and Misappropriation of Resident Property policy revealed:
*"Policy: Residents at [facility] will be treated with dignity and respect. No resident of this facility will be mistreated, abused or neglected."
*"This abuse plan has been implemented to protect our residents. The responsibility for carrying out this plan will ultimately lie with the Administrator and the staff employed by [facility] but involves every person in contact with residents."
*"Residents have the right to be free from verbal, ...physical, and mental abuse, involuntary seclusion, neglect... Residents must not be subjected to abuse by anyone..."
*"Neglect is defined as the failure to provide the goods or services necessary to maintain the health or safety of a resident. Neglect is also defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."
*"Physical Abuse is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. It may include...striking, hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching..."
*"Emotional or Psychological Abuse is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. It includes...verbal assaults, insults, threats, intimidation, humiliation, and harassment. ...Examples of verbal abuse include...yelling, screaming, using demeaning

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language to ridicule; insulting; and swearing at residents. ...Signs associated with emotional or psychological abuse include recent or sudden changes in behavior, unjustified fear, unwarranted suspicion, ...new or unexplained depression, lack of interest, or change in anxiety level."
*"The following could happen if abuse is not reported: The situation could get worse, the resident could get seriously injured, the resident could become ill, the resident could die, the person could abuse other residents..."
*"Conflict between residents, between residents and staff, or between staff members directly influences the quality of life of residents. Often, abuse situations occur as a result of conflicts that get out of control."
*"Prevention: Information will be provided to residents, families and staff informing them on how and to whom they may report concerns, incidents and grievances without the fear of retribution. The facility will provide feedback regarding the concerns that have been expressed. The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is likely to occur."
*"The most frequent abusers are caregivers and family members. Abuse usually happens because the person is overwhelmed by their own problems as well as those of the person for whom they are providing care."
*"Many factors contribute to abuse by staff including low staff ratios, inadequate supervision of staff, lack of empathy for elderly, staff personal problems, more severely ill residents, low wages, abusive or belligerent residents, job frustration, high staff turnover, cultural differences, lack of skills training and high stress."

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-"...Mental and emotional signs and symptoms of stress include...anger; ...inappropriate behavior like screaming, yelling, striking or hitting..."
*"Process:
-Identification: Staff will identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; staff will determine the direction of an investigation.
-Investigation: Alleged violations will be investigated and will be reported to proper authorities by the administrator, director of nursing or their representative
-Protection: Residents will be protected from harm during an investigation. Staff may need to be reassigned to other areas or suspended until the investigation is completed.
-Reporting/Response: The facility must report all alleged violations involving mistreatment, neglect, or abuse, including injuries on unknown source and misappropriation of resident property immediately to the administrator or their representative.
-The SD Department of Health must be notified immediately but not later than 2 hours if serious bodily injury occurred, within 24 hours of incident if no serious bodily injury.
-Notify law enforcement only for an incident or event where there is reasonable cause to suspect abuse or neglect of any resident by any person.
-The results of the investigation must be reported to the SD Department of Health, [the local police department] (if required to notify), and the SD Department of Human Services (if required to notify) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
-The facility must have evidence that all alleged violations are thoroughly investigated, and must

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F 600	Continued From page 20 prevent further abuse while the investigation is in progress. The facility must analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. -If the alleged violation is verified, appropriate corrective action, which may include termination of employment, will be taken to prevent further occurrences.	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to ensure resident property was not taken by one of one housekeeper (H) Failure to ensure the protection of resident property violated a resident's right to be free from misappropriation of resident property. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following notification of the incident. Findings include: 1. Review of the provider's 7/17/24 FRI submitted online to the SD DOH revealed:	F 602	Past noncompliance: no plan of correction required.	

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F 602	Continued From page 21 *On 7/13/24, a bag of resident 11's clothes were discovered in one of the housekeeper's (H) closets. *"The family [resident 11's family] was asked if the clothing was to be discarded, and both parties said no." *There was another shirt found in the same housekeeper's closet that belonged to a resident who had recently passed away. *"...she [housekeeper H] has been spoken to...several times about donated clothing being taken home[,] the clothes are meant to be for the residents not staff." *Housekeeper H was interviewed and said, "that she didn't get permission because when the resident was admitted she did not have many clothes, so items of clothing were donated to her, those were the ones she took." *"She also said the clothes that she took were not new, they looked ratty looking." *"[Housekeeper H] also said another resident's shirt was in the cleaning closet, but she found that in someone else's closet and before she could return the item, the resident passed away." *"It has been reviewed with [housekeeper H] that she must obtain permission from family through social services before removing...items from resident rooms. Once permission is obtained, supervisor will accompany staff removing articles from room." *The clothes were discovered in the housekeeper's closet on 7/13/24, the event was reported to the administrator on 7/15/24, and the administrator attempted to submit the required reporting on 7/15/24, 7/16/24, and 7/17/24. -They were able to submit the report on 7/17/24. The provider implemented systemic changes to ensure the deficient practice does not recur was	F 602		

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F 602	Continued From page 22 confirmed after: *Interviews with several residents throughout the facility revealed no one reported any missing personal items. *Interviews with housekeeper H and other staff (nursing, housekeeping, and laundry staff) confirmed they were knowledgeable of the revised "Personal Items Inventory" policy, the procedure for handling resident's clothing that might have needed to be replaced due to wear and tear, and about a resident's right to be free from misappropriation of property. *Record review confirmed staff were educated on the provider's updated "Personal Items Inventory" policy and procedure on 7/22/24. Based on the above information, non-compliance at F602 occurred on 7/13/24, and based on the provider's implemented corrective actions for the deficient practice confirmed on 7/22/24, the non-compliance is considered past non-compliance.	F 602	F609: For residents 2, 3, and 4; During survey, an online report was submitted to the DOH for the allegation involving resident 4. Resident 3 online report completed 8/8/24, Adult Protective Services 8/13/24 and resident 2 report completed prior to survey. Identification of other potential residents: The Social Service Designee is asking the resident if they feel safe in the facility, and for those residents with cognitive decline, the family is asked.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609	Supervisors/department heads are asking staff if any abuse/neglect/exploitation has been noted since survey. Once identified, these will be acted upon by reporting through the DOH reporting portal. Inquires with the residents and families will continue with MDS assessment timelines by the SSD and will be reported at QAPI on a quarterly basis for 6 months at which time QAPI will determine if further monitoring is needed.	8/16/24

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F 609	Continued From page 23 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to report allegations of abuse to the required entities in the required timeframe for two of two incidents of alleged abuse involving two of three sampled residents (3 and 4). Findings include: 1. Interview on 7/23/24 at 1:42 p.m. with certified nursing assistant (CNA) L about reporting of alleged violations revealed: *She was able to verbalize the correct reporting procedures. *She had not reported any incidents recently. *There were two incidents that she knew a different CNA reported last week. -Both incidents involved CNA (J). -One incident involved resident 3, and the other incident involved resident 4. -She was not present for either incident but heard about them from a coworker. 2. Refer to F600, finding 12.	F 609	Regularly scheduled full time and part time (and PRN if working) staff will be instructed on Abuse, Neglect, and Exploitation through a directed inservice, beginning 8/12/24. Any PRN staff who did not attend will be trained prior to next shift scheduled. Education/training will include all licensed and unlicensed staff and their role and responsibility for action against allegations of abuse. The Abuse/Neglect/Misappropriation of Resident Property Policy was updated to reflect these changes Under "Policy" a statement added: There is a zero tolerance for abuse at St. William's Care Center. Each staff member is a mandatory reporter for the state of SD. Under "Procedure" --The responsibility for carrying out this plan lies with all the staff employed by St. William's Care Center. The Administrator, DON, ADON, Management Team, member of the Investigative Team, Board of Directors, and the Medical Director will oversee the policy and its implementation and enforcement. Under "Training"--Staff will be instructed to use the phrase "I am reporting" or "I have an allegation" when reporting to the nurse or supervisory staff an allegation so there is no misunderstanding of intent to report.	

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	435122	A. BUILDING _____ B. WING _____	C 07/24/2024

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F 609	Continued From page 24 3. Interview on 7/23/24 at 4:49 p.m. with administrator A regarding those incidents revealed: *After nurse aide (NA) M reported the incidents to her the previous week, she texted director of nursing (DON) B. -DON B had worked a nurse shift that evening. -She told DON B to "tell [CNA J] she has to watch her interactions." *Administrator A said, "[CNA J] has a hard time with 'those residents' as in dementia." *She confirmed she knew about the incident between CNA J and resident 3. *She initially denied knowledge of the incident between CNA J and resident 4. -"[CNA J] has had trouble with [resident 4] but I'm not aware of that particular incident." -However, when detailing the incident further, especially when resident 4 expressed "He's a hateful person," administrator A did remember that incident. *She kept a daily "log" of conversations she has had throughout the day. -She could not remember exactly when NA M reported those incidents. *She confirmed she had not reported either incident to the South Dakota Department of Health (SD DOH). 4. Review of the provider's submitted reportable incidents for the past three months confirmed the incidents regarding residents 3 and 4 had not been reported to the SD DOH or other required entities. 5. Review of the provider's 7/19/24 updated Abuse, Neglect and Misappropriation of Resident Property policy revealed:	F 609	Under "Process" --Nursing staff have been instructed on methods to do the iniial reporting of such incidents. Report will be made immediately to the nurse, or supervisory staff. If reported to the supervisory staff, that staff will need to inform the nurse who will complete the initial report and make contacts as designated. These steps were added specific to reporting at the facility: The staff discovering the allegation will report the incident to the nurse on duty. The staff will submit a written account of the incident to the nurse. The nurse will make the initial report to the State of SD DOH. System change: The Administrator or her designee will review the Abuse, Neglect, Misappropriation Policy with QAPI committee for 2 months for any revisions necessary to the process of reporting allegations after which time the QAPI committee will determine if further monitoring is needed. F609 con't Numbers of allegations of abuse, neglect, and misappropriation will be reviewed with QAPI committee for 2 months at which time it will be determined if further monitoring is needed in process of reporting allegations.	

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F 609	Continued From page 25 *"Policy: Residents at [facility] will be treated with dignity and respect. No resident of this facility will be mistreated, abused or neglected." *"The following could happen if abuse is not reported: The situation could get worse, the resident could get seriously injured, the resident could become ill, the resident could die, the person could abuse other residents..." *"Process: -...Reporting/Response: The facility must report all alleged violations involving mistreatment, neglect, or abuse, including injuries on unknown source and misappropriation of resident property immediately to the administrator or their representative. -The SD Department of Health must be notified immediately but not later than 2 hours if serious bodily injury occurred, within 24 hours of incident if no serious bodily injury. -Notify law enforcement only for an incident or event where there is reasonable cause to suspect abuse or neglect of any resident by any person. -The results of the investigation must be reported to the SD Department of Health, [the local police department] (if required to notify), and the SD Department of Human Services (if required to notify) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		

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F 610	Continued From page 26 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to investigate two of two reported allegations of abuse experienced by two of three sampled residents (3 and 4). Findings include: 1. Refer to F609, finding 1. 2. Refer to F600, finding 12. 3. Interview on 7/23/24 at 4:49 p.m. with administrator A regarding the alleged incidents revealed: *One of the other certified nursing assistants (CNAs) came to her "The other day" and told her "[CNA J] is a little cross with the residents." *After nurse aide (NA) M reported the incidents to her the previous week, she texted director of nursing (DON) B. -DON B had worked a nurse shift that evening. -She told DON B to "tell [CNA J] she has to watch her interactions." *She confirmed she knew about the incident between CNA J and resident 3. *She initially denied knowledge of the incident	F 610	F610: For residents 2, 3, and 4; During survey, an online report was submitted to the DOH for the allegation involving resident 4. Resident 3 online report completed 8/8/24, Adult Protective Services 8/13/24 and resident 2 report completed prior to survey. Identification of other potential residents: All staff will be instructed on Abuse, Neglect, and Exploitation through a directed inservice, beginning 8/12/24 Education/training will include all licensed and unlicensed staff and their role and responsibility for action against allegations of abuse. The Abuse, Neglect, Misappropriation of Resident Property Policy was revised as follows: Under "Process" --A team of investigators from SWCC will conduct a thorough investigation to include supervisory staff, nurses, administrator, DON, ADON, or other designated personnel. All staff present in the area, or involved in the incident will be interviewed to ensure all facts considered. These steps were added specific to investigating at the facility: The Administrator, DON or designee for both will be notified (by the nurse completing initial report) and complete the investigative process in a timely manner per SD DOH.	8/16/24

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F 610	Continued From page 27 between CNA J and resident 4. -"[CNA J] has had trouble with [resident 4] but I'm not aware of that particular incident." -However, when detailing the incident further, especially when resident 4 expressed "He's a hateful person," administrator A did remember that incident. *She kept a daily "log" of conversations she has had throughout the day. -She could not remember exactly when NA M reported those incidents. *She confirmed she had not reported either allegation to the required entities, and she had not investigated either incident further. 4. Interview on 7/24/24 at 11:03 a.m. with administrator A about the alleged incidents revealed: *She confirmed she was not informing the other department heads, like registered nurse (RN) C the staff development coordinator, about certain incidents in an attempt to maintain confidentiality. -If an incident involved a CNA, she would have only let DON B know about the situation. -She had not considered bringing the staff development coordinator into the conversation. *Her investigation process included to: -Review schedules. -Interview those staff who were on shift and were involved. -Speak to each person individually. -Try to maintain confidentiality. *She felt the incidents involving CNA J and residents 3 and 4 were probably true because the staff member that reported those incidents was reliable. *She indicated that she started an investigation into the allegation involving resident 4 and CNA J and had submitted an initial report to the South	F 610	F610: The nurse will contact the POA/family member with a brief statement that an allegation has been made involving the resident and will reassure the family of the measures taken to ensure the resident is safe, and that the SD DOH has been notified. The primary care provider will also be contacted. The investigative process will involve the Administrator or designee, any supervisor staff necessary to assist in the interview process—it may involve more than one supervisory staff. These staff have the understanding that the information is confidential and used to determine further employment of the employee. The report will be written up, reviewed by the Administrator and submitted on the reporting portal. System change: The Administrator or her designee will review the Abuse, Neglect, Misappropriation Policy with QAPI committee for 2 months for any revisions necessary to the process of thorough investigations of allegations after which time the QAPI committee will determine if further monitoring is needed. Numbers of allegations of abuse, neglect, and misappropriation will be reviewed with QAPI committee for 2 months at which time it will be determined if further monitoring is needed in process of investigation allegations thoroughly.	8/16/24

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F 610	Continued From page 28	F 610		

Dakota Department of Health.

5. Review of the provider's 7/19/24 updated Abuse, Neglect and Misappropriation of Resident Property policy revealed:
*"Policy: Residents at [facility] will be treated with dignity and respect. No resident of this facility will be mistreated, abused or neglected."
*"This abuse plan has been implemented to protect our residents. The responsibility for carrying out this plan will ultimately lie with the Administrator and the staff employed by [facility] but involves every person in contact with residents."
*"Process:
-Identification: Staff will identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; staff will determine the direction of an investigation.
-Investigation: Alleged violations will be investigated and will be reported to proper authorities by the administrator, director of nursing or their representative
-Protection: Residents will be protected from harm during an investigation. Staff may need to be reassigned to other areas or suspended until the investigation is completed.
-Reporting/Response: The facility must report all alleged violations involving mistreatment, neglect, or abuse, including injuries on unknown source and misappropriation of resident property immediately to the administrator or their representative.
-The SD Department of Health must be notified immediately but not later than 2 hours if serious bodily injury occurred, within 24 hours of incident if no serious bodily injury.
-Notify law enforcement only for an incident or

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F 610	Continued From page 29 event where there is reasonable cause to suspect abuse or neglect of any resident by any person. -The results of the investigation must be reported to the SD Department of Health, [the local police department] (if required to notify), and the SD Department of Human Services (if required to notify) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. -The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further abuse while the investigation is in progress. The facility must analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. -If the alleged violation is verified, appropriate corrective action, which may include termination of employment, will be taken to prevent further occurrences.	F 610		
F 761 SS=D	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.	F 761		

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F 761	Continued From page 30 §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 interview, observation, and policy review, the provider failed to follow their policy to ensure a controlled medication (one easily diverted by staff) was securely stored for one of one (1) resident. Findings include: 1. Interview on 7/23/24 at 12:46 p.m. and again at 2:09 p.m. with medication aide (MA) E revealed: *Resident 1 received Tramadol (a controlled pain medication) 50 milligrams (mg) tablet twice daily. *The Tramadol 50 mg tablets were kept in the same location as other scheduled dose medications and were not double-locked. *She was aware Tramadol was a controlled substance medication. *Controlled medications that were for PRN (as needed) use were stored in the double-locked drawer are were counted at shift change. *Scheduled controlled medications were counted before and after they were administered. *She confirmed they do not count the scheduled controlled medications at shift change. 2. Interview on 7/24/24 at 9:47 a.m. with licensed practical nurse (LPN) D revealed: *PRN Tramadol was stored in the double-lock box in the medication cart.	F 761	F761: The Controlled Substance-Narcotic Medication Management Policy was updated to state PRN and select scheduled II-V medications are maintained in separately locked, permanently affixed compartment of the medication cart. Controlled substances that are prescribed on a PRN basis and select scheduled medications are to be signed into the individual narcotic control sheets immediately upon receipt from the pharmacy. Complete documentation in the narcotic book prior to administering a PRN or select scheduled controlled substance to the resident. The policy was updated to list controlled (scheduled and PRN) medications that need to be kept in the double locked drawer, as well as a list of controlled medications that are scheduled and can be kept with the residents regularly scheduled medications. Counts are confirmed as the medication is administered. If nursing staff are unsure if a controlled medication can be placed with the regularly scheduled medications the consultant pharmacist will be consulted.	8/16/24

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F 761	Continued From page 31 *Only the scheduled controlled medications like Tramadol and Clonazepam (a sedative) are kept with other scheduled medications. 3. Observation on 7/24/24 at 10:32 a.m. with MA E revealed: *She removed a current Tramadol dosing card for resident 1, from the top drawer of the medication cart. *That drawer was only secured by one lock. 4. Interview on 7/24/24 at 11:58 a.m. with director of nursing (DON) B revealed: *Scheduled Tramadol is kept with other scheduled medications in the medication cart. *PRN narcotic medications are in the double-lock drawer. *This is the provider's normal practice for controlled medications. *The double-lock drawer is not big enough for all the controlled medications. *She agreed that having the scheduled Tramadol doses with other scheduled medications did not follow their current Controlled Substance-Narcotic Medication Management Policy. 5. Review of the provider's 7/14/23 Controlled Substance-Narcotic Medication Management policy revealed: *"All scheduled II-V medications are maintained in separately locked, permanently affixed compartment of the medication cart." *"All controlled substances, including ER narcotic kit and medications in the refrigerator, must be counted at each shift change."	F 761	System change: The DON or her designee will review the individual narcotic control sheets on a weekly basis for 1 month, then on a monthly basis for 6 months, then random thereafter. Findings will be reported monthly to QAPI committee who will determine if further monitoring is needed.	