<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
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<tr>
<td>F 281</td>
<td>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</td>
<td>I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's ongoing efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.</td>
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The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, resident and staff interview, the facility failed to observe the administration of medications for 1 of 1 resident. (Resident #33)

The findings include:

A facility policy entitled Administering Medication with a revision date of April 2010 read in part: individuals administering medication must initial the resident's MAR on the appropriate line after giving each medication.

Resident #33 was admitted October 16, 2012 with diagnoses of congestive heart failure, hypertension and atrial fibrillation. An interim plan of care dated 10/16/12 for potential fluid imbalance and risk for cardiovascular complications listed an intervention to administer medications as ordered. An admission Minimum Data Set (MDS) dated 10/23/12 indicated the Resident was cognitively intact. Review of Resident #33's medical record revealed no order for self-administration of medications.

During an observation of Resident #33's room on 11/01/12 at 8:44 AM, Resident #33 was not observed in the room and a medication cup was noted at bedside. The medication cup contained four pills.

Any CCC resident could be affected by deficient practice. Resident #33 stated she took her medication after breakfast which is her normal practice. In order for such occurrence not to be repeated the following actions will be taken: all nurses will be in-serviced on Medication Administration Policy and Procedures as well as guidelines for self-medication.
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Review of Resident #33's November 2012 Medication Administration Record (MAR) revealed the 8:00 AM medications were documented as given with Nurse #1's initials.

An interview with Nurse #1 on 11/01/12 at 9:11 AM revealed she completed her morning medication pass at 6:00 AM and no residents were assessed to independently administer medications. Nurse #1 also confirmed Resident #33's morning meds were Folic Acid 1 milligram (mg), Multivitamin, Sotalol 80 mg and Lasix 40mg.

An interview with Resident #33 on 11/01/12 at 9:15 AM revealed the medications were left at bedside that morning by Nurse #1, because Resident #33 did not want to take them until after breakfast. The Resident also stated Nurse #1 typically gave her the medications after breakfast. The Resident added she had taken her medications independently when she returned to her room from breakfast.

During a follow up interview with Nurse #1 on 11/01/12 at 3:20 PM, Nurse #1 acknowledged she left the medications at bedside after assisting Resident #33 to the bathroom and knew medications were not to be left at bedside. Nurse #1 also stated she did not witness Resident #33 take her medication and was unsure if she had taken them. Nurse #1 also acknowledged she signed the MAR prior to administering the medication and should not have signed the MAR until she had witnessed Resident #33 consume the medications.

Nurse #1 was in-serviced in Medication Administration on 11/02/2012.

All nurses will be in-serviced on Medication Administration Policy & Procedures by the DON or designee.

This in-service will be conducted on a yearly basis to assure competency in this area. In-services will be completed by The DON or designee.

In order to assure deficient practice in Medication Administration does not reoccur, the DON or designee will complete random audits of nurses administering medication every week for one month, monthly for three months and quarterly thereafter. Audits will be completed using “QA Audit for Medication Administration Compliance” form to show date, time, and place of audit as well as observation of Medication Administration. Pharmacy consultant will observe Medication Administration during his quarterly visits. DON will be in charge of all audits and findings.
**Summary Statement of Deficiencies**

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**Results of Audit**

During an interview with the Director of Nursing (DON) on 11/2/12 at 10:00 AM, the DON explained she expected nurses to observe residents during medication administration to ensure medications were taken and to sign the MAR after the medications were taken and document refusals if necessary.

Results of audit will be reviewed by Interdisciplinary Team following each audit on a weekly, monthly and quarterly basis. Quarterly QA committee will review audits comparing with Policy and Procedures.

The facility will utilize the in-service records and auditing tools to measure compliance and to assure that solutions have been achieved and sustained.

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<td>12/07/2012</td>
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