**SUMMARY STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td></td>
</tr>
<tr>
<td>F 658</td>
<td>Services Provided Meet Professional Standards</td>
<td>F 658</td>
<td>7/20/20</td>
</tr>
</tbody>
</table>

§483.21(b)(3)(i) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

1. Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:

Based on observations, record review, and resident and staff interviews a nurse failed to stay in the presence of a resident to ensure medications provided were administered for 1 of 4 residents (Resident #1) observed for medication administration.

Findings included:

- Resident #1 was admitted to the facility 06/17/16 with diagnoses including heart failure and hypertension (high blood pressure).
- Review of Resident #1’s Physician orders revealed an order dated 08/30/17 for peridex 0.12% rinse (a medication to help with red and swollen gums) twice daily and Resident #1 may keep the medication at the bedside. Resident #1 also had a Physician’s order dated 05/11/20 for Metamucil sugar-free one teaspoon in a full glass of water by mouth twice a day as needed for constipation and may keep at bedside.
- Immediate
- The facility Licensed Nurse on duty returned to the room to ensured that Resident #1 took her medication. The Licensed Nurse was educated by the Director of Nursing (DON) on not leaving

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.
**Review of the quarterly Minimum Data Set (MDS) dated 04/21/20 revealed Resident #1 was cognitively intact and received diuretics 7 out of 7 days in the look back period.**

Review of Resident #1’s care plan for self-administration of medication last updated 04/21/20 revealed she had been assessed and was capable of self-administration. Interventions included assessing Resident #1’s ability to self-administer medications as needed and observing her self-administration frequently.

An observation of medication administration on 06/22/20 at 7:55 AM by Nurse #1 revealed she entered Resident #1’s room with one medication cup containing 2 calcium carbonate tablets and one medication cup containing 2 eye multivitamin capsules, 2 senna tablets (a medication for constipation), 1 furosemide (a diuretic) 80 milligrams (mg) tablet, and 1 potassium 20 milliequivalents (mEq) tablet, and 1 bottle of calcitonin nasal spray (a medication for osteoporosis). Nurse #1 placed the 2 medication cups and bottle of nasal spray on Resident #1’s meal tray and exited the room.

An interview with Resident #1 on 06/22/20 at 8:01 AM revealed she had resided in the facility for 4 years and the nurses always left her medication in her room and she took the medications when she was ready. Resident #1 stated it was too much for the nurses to come in and give her medications as ordered so they left them for her to take. Resident #1 stated the medications were just vitamins.

An interview with Nurse #1 on 06/22/20 at 8:03 AM revealed she left medication in Resident #1’s medication at the bedside on 6/22/20.

Identification of Others
The DON and ADON completed a facility tour to ensure that medications were not left at the bedside for current facility residents on 6/22/20.

Systematic Changes
Facility Licensed Nurses were inserviced by the ADON/SDC on The Five Rights of Medication Administration, and following physician’s orders, specifically not leaving medications at the bedside beginning 6/23/20 and completed on 7/11/20.

The DON or ADON will complete random Medication Pass Observations three times a week for eight weeks, then two times a week for four weeks. Additional training will be provided as needed.

Newly hired Licensed Nurses will receive training on The Five Rights of Medication Administration, and following physician’s orders, specifically not leaving medications at the bedside during their orientation period.

Facility Ambassadors, during their Ambassador Rounds, will monitor that medications are not being left at the bedside for the next twelve weeks beginning on 7/9/20.

Monitoring Process
Findings of the Medication Pass Observations and Ambassador Monitoring
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 658</td>
<td>Continued From page 2</td>
<td></td>
<td>room and did not observe Resident #1 take the medication. Nurse #1 stated she always left Resident #1's medication in her room and she took them when she was ready. Nurse #1 acknowledged nurses were supposed to watch residents take the medication at the time of administration. An interview with the Director of Nursing (DON) on 06/22/20 at 8:10 AM revealed Resident #1 had been assessed to self-administer medications and was a candidate for self-administration for the medications that were ordered to be kept at her bedside. The DON stated nurses were expected to watch residents take their medication at the time it was administered unless ordered otherwise from the Physician. An interview with the Nurse Practitioner (NP) on 06/22/20 at 1:27 PM revealed she expected nurses to stay with residents and watch them take the medication at the time of administration unless the resident had orders for the resident to self-administer medication. An interview with the Administrator on 06/22/20 at 3:35 PM revealed he expected nurses to stay with residents while they took their medications unless there was an order stating they could administer their own medication.</td>
<td>F 658</td>
<td>Rounds will be reported to the Facility Quality Assurance and Performance Improvement Committee Meeting by the DON monthly for the next three months. If necessary, the Quality Assurance and Performance Improvement Committee will modify this plan to ensure the facility remains in compliance.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>