STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	PO BOX 370 MATHEWS, VA 23109

(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 An unannounced Medicaid standard survey was conducted on 4/26-28/2017. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety report will follow. The census in this 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 14 current resident reviews (Residents 1-13 and 16) and 2 closed record reviews (Residnts 14 and 15).	F 000		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility record review and clinical record review, the facility staff failed to follow the professional standards of nursing practice for two residents (Resident #10 and #11) of the 16 residents in the survey sample. 1. For Resident #10, a discontinued medication (Metoclopramide) was administered during medication pour and pass administration observations. 2. For Resident #11, one ophthalmic (eye) medication was ordered to be administered as	F 281	F- 281 Services Provided Meet Professional Standards 1. The DON educated licensed nurse (A) responsible for the medication error for resident #10 and #11 by review of Medication Administration policy and procedure with focus on triple check of medications prior to administration and the importance of following Provider orders. The Provider and Responsible Party were notified of the medication errors for both residents on 4/27/17. No adverse event occurred for resident #10 or #11 as a result of the medication error.	5/31/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/08/2017

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F 281	Continued From page 1 two drops in each eye, and only one drop was administered in each eye during medication pour and pass administration observations. The findings included: 1. Resident #10 was admitted to the facility on 9-22-11. Diagnoses for Resident #10 included but are not limited to; congestive heart failure, respiratory failure, osteoarthritis, chronic obstructive pulmonary disease, dysthymic disorder, gastro-esophageal reflux disorder, hypertension, anxiety, atrial fibrillation, skin cancer, mild cognitive impairment, and gastro-intestinal bleed. Resident #10's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2-8-17, was a full annual assessment, and coded Resident #10 with a BIMS (Brief Interview of Mental Status) score of 15 out of 15 possible points, revealing the Resident as cognitively intact. In addition, the MDS coded Resident #10 as needing set up assistance only for all Activities of Daily Living (ADL) care, with the exception of bathing, for which the Resident was dependant on one staff members assistance. On 4-27-17 at approximately 8:25 a.m., during a Medication Pour and Pass observation, Resident #10 was seen in her room, sitting on the edge of her bed. LPN (A) washed her hands, and proceeded to take medications from the medication cart. Resident #10's medication baggie for that administration time, was removed and the baggie had to be ripped open, which revealed multiple single dose medications in individual blister wrappers, inside of the baggie. This was while LPN (A) reviewed Resident #10's	F 281	2. All residents within the facility who receive oral medications and eye drops are potentially at risk for receiving the incorrect dose. 3. DON/Designee will in-service the licensed nurses on the facility policy of medication administration and the 6 Rights of Medication Administration May 17, 2017 and May 18, 2017. 4. Medication Administration Audits will be performed by the DON/Designee for (4) nurses weekly for one month, (4) nurses monthly for three months; and then 1 per month to ensure medications are being provided per the Provider orders. The results of the audits will be reported at the QA meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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F 281	Continued From page 2	F 281		

eMAR (computerized Medication Administration Record).

After LPN (A) reviewed the eMAR, she handed each unopened medication to the surveyor to record the name, dose, and expiration date of each medication. LPN (A) then opened all of the tablets and popped them into a plastic clear 30 milliliter graduated medication cup for administration to the Resident. Resident #10 accepted the 11 tablets the nurse prepared for her, in the plastic medication cup, and swallowed them with water. The Resident also received Biotine oral liquid mouth rinse 5 milliliters, and Spiriva, an inhaled steroid, along with the 11 tablets.

The 11 tablets contained in the medication cup which were administered by LPN (A) are listed as follows;
1. Potassium Chloride 10 milliequivalents one tablet.
2. Vitamin D-3 2000 international units one tablet.
3. Venlafaxine 150 milligrams one and one half tablets.
4. Lasix 80 milligrams one tablet.
5. Tylenol 325 milligrams two tablets.
6. Multivitamin one tablet.
7. Spironalactone 25 milligrams one tablet.
8. Carvedilol 25 milligrams one tablet.
9. Metoclopramide 5 milligrams one tablet.

On 4-27-17 at 9:30 a.m. a review of the medications administered during the Medication Pour and Pass Observation was conducted. Review of the physician's order sheets (POS), and Medication Administration Records (MAR) revealed that the Metoclopramide medication

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F 281	Continued From page 3	F 281		

administered to Resident #10, that morning, had been discontinued on 9-26-16.

The director of nursing (DON) provided a copy of the investigation completed by her when she was notified that this error had during the observation by the surveyor. The investigation revealed that the Resident was receiving the Metoclopramide from the pharmacy, as the pharmacy staff stated they had never received the discontinue order from the facility via fax. The DON went on to say that all orders must be faxed to the pharmacy, as the facility computer system does not communicate with the pharmacy, and it was unknown if the Resident received one or multiple doses of this unnecessary medication, as it was no longer to be signed for on the MAR, and it was unknown if it was given or held.
LPN (A) agreed it was an error.

On 4-27-17 at 5:00 p.m., during a briefing with the administrator and the DON, the concerns regarding the administration of an unnecessary medication to Resident #10 was discussed. The DON stated that the expectation was for the nursing staff to administer only medications that were ordered, and to follow the MAR while administering medications.

The facility cited "Mosby" as the nursing reference used in the facility for professional nursing standards.

The facility's policy on "Medication Administration" included the following;
"F". bullet #1, and #2, Refer to the MAR to review drugs; verify medication strength, dose, and labeled directions. Never pass medications from memory.

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Guidance was given to nursing by Mosby's "Fundamentals of Nursing 7th Edition, Potter-Perry, p. 713, "After administering a medication, record it immediately on the appropriate record form. Never chart a medication before administering it. Recording immediately after administration prevents errors. The recording of a medication includes the name of the medication, dose, route, and exact time of administration."

The administration was informed of the findings on 4-27-17 at 5:00 p.m. No further information was provided.

2. Resident #11 was admitted to the facility on 8-31-16. Diagnoses for Resident #11 included but are not limited to; Autism, Vitamin B deficiency, Diabetes, and osteoarthritis.

Resident #11's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2-22-17, was a quarterly assessment, and coded Resident #11 with a BIMS (Brief Interview of Mental Status) score of 7 out of 15 possible points, revealing the Resident was cognitively impaired. In addition, the MDS coded Resident #11 as dependant on staff assistance for all Activities of Daily Living (ADL) care.

On 4-27-17 at approximately 8:35 a.m., during a Medication Pour and Pass observation, Resident #11 was seen in her room, sitting up in her bed. LPN (A) reviewed Resident #11's eMAR (computerized Medication Administration Record), washed her hands, and proceeded to

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take medications from the medication cart. Resident #11's eye drops were removed from the medication cart and carried into the Resident's room. LPN (A) was observed instilling one drop of the medication into each eye, and left the room. LPN (A) was asked how many drops she put in each of the Resident's eyes, and she answered "one in each eye", as was observed.

After LPN (A) reviewed the eMAR, she handed each unopened medication to the surveyor to record the name, dose, and expiration date of each medication. LPN (A) then opened all of the tablets and popped them into a plastic clear 30 milliliter graduated medication cup for administration to the Resident. Resident #11 accepted the 9 tablets the nurse prepared for her, in the plastic medication cup, and swallowed them with water. The Resident also received the one eye drop, as described above.

The 9 tablets contained in the medication cup, and the one eye drop, which were administered by LPN (A) are listed as follows;
1. Potassium Chloride 20 milliequivalents one tablet.
2. Vitamin D-3 1000 international units one tablet.
3. Calcium (Tums) 500 milligrams one tablet.
4. Lasix 40 milligrams one tablet.
5. Senexon 8.6/50 milligrams two tablets.
6. Amlodipine 5 milligrams one tablet.
7. Tramadol 50 milligrams one tablet.
8. Folic Acid 1 milligram one tablet.
9. Genteal Tears 2 drops in each eye.

On 4-27-17 at 9:30 a.m. a review of the medications administered during the Medication Pour and Pass Observation was conducted.

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F 281	Continued From page 6	F 281		

Review of the physician's order sheets (POS), and Medication Administration Records (MAR) revealed that the Genteal tears medication administered to Resident #11, that morning, had been insufficient, and only one drop was given in each eye, when two drops in each eye was ordered.

The director of nursing (DON) stated that LPN (A) agreed that only one drop was administered in each eye, and that the error had occurred, and the nurse would be re-educated.

On 4-27-17 at 5:00 p.m., during a briefing with the administrator and the DON, the concerns regarding the in sufficient administration of a physician ordered eye drop medication to Resident #11 was discussed. The DON stated that the expectation was for the nursing staff to administer all medications per physician's orders.

The facility cited "Mosby" as the nursing reference used in the facility for professional nursing standards.

The facility's policy on "Medication Administration" included the following;
"F". bullet #1, and #2, Refer to the MAR to review drugs; verify medication strength, dose, and labeled directions. Never pass medications from memory.

Guidance was given to nursing by Mosby's "Fundamentals of Nursing 7th Edition, Potter-Perry, p. 713, "After administering a medication, record it immediately on the appropriate record form. Never chart a medication before administering it. Recording immediately after administration prevents errors.

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F 281	Continued From page 7 The recording of a medication includes the name of the medication, dose, route, and exact time of administration." The administration was informed of the findings on 4-27-17 at 5:00 p.m. No further information was provided.	F 281		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the	F 329		5/31/17

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F 329	Continued From page 8 medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility record review, the facility staff failed to ensure residents were free from unnecessary medications, for one resident (Resident #10) of 16 residents in the survey sample. 1. For Resident #10, a discontinued medication (Metoclopramide) was administered during medication pour and pass administration observations. The findings included: 1. Resident #10 was admitted to the facility on 9-22-11. Diagnoses for Resident #10 included but are not limited to; congestive heart failure, respiratory failure, osteoarthritis, chronic obstructive pulmonary disease, dysthymic disorder, gastro-esophageal reflux disorder, hypertension, anxiety, atrial fibrillation, skin cancer, mild cognitive impairment, and gastro-intestinal bleed. Resident #10's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2-8-17, was a full annual assessment, and coded Resident #10 with a BIMS (Brief Interview	F 329	F- 329 Drug Regimen is free from Unnecessary Drugs 1. The DON educated licensed nurse (A) responsible for the medication error for resident #10 by review of Medication Administration policy and procedure with focus on triple check of medications prior to administration and the importance of following Provider orders. The Provider and Responsible Party were notified of the medication error on 4/27/17. Resident #10 had no adverse outcomes from the medication error. The resident's medications were audited and all were correct as ordered on 04/28/17. 2. All residents are at potential risk for administration of incorrect medication. DON/Designee will complete a 100% comparison of pharmacy orders to current EMR by May 12, 2017. 3. Nurse Educator will provide education to licensed staff on 6 Rights of Medication Administration and process of printing all orders from the EMR, faxing and obtaining confirmation of fax to pharmacy by May 31, 2017. 4. DON/Designee is coordinating a new process with the pharmacy that will assist	

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F 329	Continued From page 9 of Mental Status) score of 15 out of 15 possible points, revealing the Resident as cognitively intact. In addition, the MDS coded Resident #10 as needing set up assistance only for all Activities of Daily Living (ADL) care, with the exception of bathing, for which the Resident was dependant on one staff members assistance. On 4-27-17 at approximately 8:25 a.m., during a Medication Pour and Pass observation, Resident #10 was seen in her room, sitting on the edge of her bed. LPN (A) washed her hands, and proceeded to take medications from the medication cart. Resident #10's medication baggie for that administration time, was removed, and the baggie had to be ripped open, which revealed multiple single dose medications in individual blister wrappers, inside of the baggie, while LPN (A) reviewed Resident #10's eMAR (computerized Medication Administration Record). After LPN (A) reviewed the eMAR, she handed each unopened medication to the surveyor to record the name, dose, and expiration date of each medication. LPN (A) then opened all of the tablets and popped them into a plastic clear 30 milliliter graduated medication cup for administration to the Resident. Resident #10 accepted the 11 tablets the nurse prepared for her, in the plastic medication cup, and swallowed them with water. The Resident also received Biotine oral liquid mouth rinse 5 milliliters, and Spiriva, an inhaled steroid, along with the 11 tablets. The 11 tablets contained in the medication cup which were administered by LPN (A) are listed as follows;	F 329	to review and compare all daily order changes for accuracy between the facility EMR and the pharmacy starting May 8, 2017. DON/Designee will complete med pass audit to include 6 rights of med administration and med reconciliation for (4) residents weekly for one month, (4) residents monthly for three months; and then (1) per month. The results of the audits will be reported monthly by the DON/Designee at the QA meeting for evaluation of compliance and ongoing for monitoring for continuous improvement or if any modifications to the action plan are necessary after the implementation	

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F 329	Continued From page 10	F 329		

1. Potassium Chloride 10 milliequivalents one tablet.
2. Vitamin D-3 2000 international units one tablet.
3. Venlafaxine 150 milligrams one and one half tablets.
4. Lasix 80 milligrams one tablet.
5. Tylenol 325 milligrams two tablets.
6. Multivitamin one tablet.
7. Spironalactone 25 milligrams one tablet.
8. Carvedilol 25 milligrams one tablet.
9. Metoclopramide 5 milligrams one tablet.

On 4-27-17 at 9:30 a.m. a review of the medications administered during the Medication Pour and Pass Observation was conducted. Review of the physician's order sheets (POS), and Medication Administration Records (MAR) revealed that the Metoclopramide medication administered to Resident #10 that morning, had been discontinued on 9-26-16.

The director of nursing (DON) provided a copy of the investigation completed by her when she was notified that this error had occurred by the surveyor. The investigation revealed that the Resident was receiving the Metoclopramide from the pharmacy, as the pharmacy staff stated they had never received the discontinue order from the facility via fax. The DON went on to say that all orders must be faxed to the pharmacy, as the facility computer system does not communicate with the pharmacy, and it was unknown if the Resident received one or multiple doses of this unnecessary medication, as it was no longer to be signed for on the MAR, and it was unknown if it was given or held.
LPN (A) agreed it was an error.

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F 329	Continued From page 11 On 4-27-17 at 5:00 p.m., during a briefing with the administrator and the DON, the concerns regarding the administration of an unnecessary medication to Resident #10 was discussed. The DON stated that the expectation was for the nursing staff to administer only medications that were ordered, and to follow the MAR while administering medications. The Resident's care plan stated to administer medications according to physician's orders. The facility's policy on "Medication Administration" included the following; "F". bullet #1, and #2, Refer to the MAR to review drugs; verify medication strength, dose, and labeled directions. Never pass medications from memory. The administration was informed of the findings on 4-27-17 at 5:00 p.m. No further information was provided.	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure medications were administered with less than a 5% medication error rate for two Residents (Residents #10, & #11). 26 medication administration opportunities	F 332	F-332 Free of Medication Error Rates of 5% or More 1. The DON educated licensed nurse (A) responsible for the medication errors for resident #10 and resident # 11 by review of Medication Administration policy	5/31/17

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F 332	Continued From page 12 were observed with 2 errors, resulting in a 7.6% error rate. 1. For Resident #10, a discontinued medication (Metoclopramide) was administered during medication pour and pass administration observations. 2. For Resident #11, one ophthalmic (eye) medication was ordered to be administered as two drops in each eye, and only one drop was administered in each eye during medication pour and pass administration observations. The findings included: 1. Resident #10 was admitted to the facility on 9-22-11. Diagnoses for Resident #10 included but are not limited to; congestive heart failure, respiratory failure, osteoarthritis, chronic obstructive pulmonary disease, dysthymic disorder, gastro-esophageal reflux disorder, hypertension, anxiety, atrial fibrillation, skin cancer, mild cognitive impairment, and gastro-intestinal bleed. Resident #10's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2-8-17, was a full annual assessment, and coded Resident #10 with a BIMS (Brief Interview of Mental Status) score of 15 out of 15 possible points, revealing the Resident as cognitively intact. In addition, the MDS coded Resident #10 as needing set up assistance only for all Activities of Daily Living (ADL) care, with the exception of bathing, for which the Resident was dependant on one staff members assistance. On 4-27-17 at approximately 8:25 a.m., during a	F 332	and procedure with focus on triple check of medications prior to administration and the importance of following Provider orders. The resident #10 had a discontinued medication administered during medication pass. Resident #11 received one ophthalmic medication administered in each eye instead of two during medication pass. The residents had no adverse outcome from either administration error. The residents Provider and Responsible Parties were made aware of the error on 04/27/17. 2. All residents are at risk for medication errors during the medication administration. 3. Nurse Educator/ Designee will educate nursing staff on the 6 rights of medication administration, process of printing faxing all orders and obtaining confirmations of fax's to the pharmacy by May 31, 2017. 4. DON/Designee will complete medication pass audits to include 6 rights of medication administration and reconciliations for (4) residents per week for one month, (4) residents monthly for three months; and then 1 per month. The results of the audits will be reported monthly by the DON/Designee at the QA meeting for evaluation of compliance and ongoing for monitoring for continuous improvement or if any modifications to the action plans are necessary after the implementation.	

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	49E215	A. BUILDING _____ B. WING _____	04/28/2017

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Medication Pour and Pass observation, Resident #10 was seen in her room, sitting on the edge of her bed. LPN (A) washed her hands, and proceeded to take medications from the medication cart. Resident #10's medication baggie for that administration time, was removed, and the baggie had to be ripped open, which revealed multiple single dose medications in individual blister wrappers, inside of the baggie, while LPN (A) reviewed Resident #10's eMAR (computerized Medication Administration Record).

After LPN (A) reviewed the eMAR, she handed each unopened medication to the surveyor to record the name, dose, and expiration date of each medication. LPN (A) then opened all of the tablets and popped them into a plastic clear 30 milliliter graduated medication cup for administration to the Resident. Resident #10 accepted the 11 tablets the nurse prepared for her, in the plastic medication cup, and swallowed them with water. The Resident also received Biotine oral liquid mouth rinse 5 milliliters, and Spiriva, an inhaled steroid, along with the 11 tablets.

The 11 tablets contained in the medication cup which were administered by LPN (A) are listed as follows;
1. Potassium Chloride 10 milliequivalents one tablet.
2. Vitamin D-3 2000 international units one tablet.
3. Venlafaxine 150 milligrams one and one half tablets.
4. Lasix 80 milligrams one tablet.
5. Tylenol 325 milligrams two tablets.
6. Multivitamin one tablet.
7. Spironalactone 25 milligrams one tablet.

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F 332	Continued From page 14 8. Carvedilol 25 milligrams one tablet. 9. Metoclopramide 5 milligrams one tablet. On 4-27-17 at 9:30 a.m. a review of the medications administered during the Medication Pour and Pass Observation was conducted. Review of the physician's order sheets (POS), and Medication Administration Records (MAR) revealed that the Metoclopramide medication administered to Resident #10, that morning, had been discontinued on 9-26-16. The director of nursing (DON) provided a copy of the investigation completed by her when she was notified that this error had occurred by the surveyor. The investigation revealed that the Resident was receiving the Metoclopramide from the pharmacy, as the pharmacy staff stated they had never received the discontinue order from the facility via fax. The DON went on to say that all orders must be faxed to the pharmacy, as the facility computer system does not communicate with the pharmacy, and it was unknown if the Resident received one or multiple doses of this unnecessary medication, as it was no longer to be signed for on the MAR, and it was unknown if it was given or held. LPN (A) agreed it was an error. On 4-27-17 at 5:00 p.m., during a briefing with the administrator and the DON, the concerns regarding the administration of an unnecessary medication to Resident #10 was discussed. The DON stated that the expectation was for the nursing staff to administer only medications that were ordered, and to follow the MAR while administering medications.	F 332		

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The facility's policy on "Medication Administration" included the following;
"F". bullet #1, and #2, Refer to the MAR to review drugs; verify medication strength, dose, and labeled directions. Never pass medications from memory.

The administration was informed of the findings on 4-27-17 at 5:00 p.m. No further information was provided.

2. Resident #11 was admitted to the facility on 8-31-16. Diagnoses for Resident #11 included but are not limited to; Autism, Vitamin B deficiency, Diabetes, and osteoarthritis.

Resident #11's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2-22-17, was a quarterly assessment, and coded Resident #11 with a BIMS (Brief Interview of Mental Status) score of 7 out of 15 possible points, revealing the Resident was cognitively impaired. In addition, the MDS coded Resident #11 as dependant on staff assistance for all Activities of Daily Living (ADL) care.

On 4-27-17 at approximately 8:35 a.m., during a Medication Pour and Pass observation, Resident #11 was seen in her room, sitting up in her bed. LPN (A) reviewed Resident #11's eMAR (computerized Medication Administration Record), washed her hands, and proceeded to take medications from the medication cart. Resident #11's eye drops were removed from the medication cart and carried into the Residents room. LPN (A) was observed instilling one drop of the medication into each eye, and left the

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room. LPN (A) was asked how many drops she put in each of the Resident's eyes, and she answered "one in each eye", as was observed.

After LPN (A) reviewed the eMAR, she handed each unopened medication to the surveyor to record the name, dose, and expiration date of each medication. LPN (A) then opened all of the tablets and popped them into a plastic clear 30 milliliter graduated medication cup for administration to the Resident. Resident #11 accepted the 9 tablets the nurse prepared for her, in the plastic medication cup, and swallowed them with water. The Resident also received The one eye drop, as described above.

The 9 tablets contained in the medication cup, and the one eye drop, which were administered by LPN (A) are listed as follows;
1. Potassium Chloride 20 milliequivalents one tablet.
2. Vitamin D-3 1000 international units one tablet.
3. Calcium (Tums) 500 milligrams one tablet.
4. Lasix 40 milligrams one tablet.
5. Senexon 8.6/50 milligrams two tablets.
6. Amlodipine 5 milligrams one tablet.
7. Tramadol 50 milligrams one tablet.
8. Folic Acid 1 milligram one tablet.
9. Genteal Tears 2 drops in each eye.

On 4-27-17 at 9:30 a.m. a review of the medications administered during the Medication Pour and Pass Observation was conducted. Review of the physician's order sheets (POS), and Medication Administration Records (MAR) revealed that the Genteal tears medication administered to Resident #11, that morning, had been insufficient, and only one drop was given in

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each eye, when two drops in each eye was ordered.

The director of nursing (DON) stated that LPN (A) agreed that only one drop was administered in each eye, and that the error had occurred, and the nurse would be re-educated.

On 4-27-17 at 5:00 p.m., during a briefing with the administrator and the DON, the concerns regarding the in sufficient administration of a physician ordered eye drop medication to Resident #11 was discussed. The DON stated that the expectation was for the nursing staff to administer all medications per physician's orders.

The facility's policy on "Medication Administration" included the following;
"F". bullet #1, and #2, Refer to the MAR to review drugs; verify medication strength, dose, and labeled directions. Never pass medications from memory.

The administration was informed of the findings on 4-27-17 at 5:00 p.m. No further information was provided.