STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146043	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Manor Health Care	485 South Friendship Drive Nashville, IL 62263

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33205 Based on observation, interview and record review, the facility failed to secure and control the disposition of administered medications for 5 of 5 residents (R1, R2, R3, R6, R7) in the sample of 10 reviewed for disposition of medication. Findings include: 1. R1's Face sheet dated 6/6/24 documents, R1 was admitted [DATE] with a diagnosis in part of: unspecified dementia, parkinsonism, generalized anxiety disorder, depression, other abnormalities of gait and mobility, muscle wasting and atrophy, dysphagia, anorexia. R1's Brief Interview of Mental Status, (BIMS), dated 4/27/24 documents, R1 as cognitively intact and requires moderate assistance for activities of daily living, (ADLs). R1's Care Plan dated 5/9/24 documents, focus area of cognitive deficient related to dementia: medications (meds) as ordered by physician, vision impairment related to wears prescription lenses, requires assist with ADLs, receives psychotropic medications related to depression, insomnia, anxiety, receives pain medication therapy related to left hip fracture, osteoporosis, scoliosis: administered pain medications as ordered. R1's Physician Order Sheet, (POS), dated 5/6/24-6/6/24 documents, hydrocortisone cream 2.5% apply to left hip topically every day and night for pain, diclofenac gel 1%, apply to left hip topically every day and night shift for pay, apply 4 grams. R1's POS does not document an order for medications at bedside. On 6/4/24 at 9:06am, R1 was in her wheelchair coming from the dining room after breakfast. R1 stated she gets meds at the bedside part of the time and has been here a month. R1 had Hydrocortisone cream tucked under her let thigh in her wheelchair. On 6/7/2024 at 10:45AM, R1 stated, she has the Hydrocortisone, with her at all times in her wheelchair because, she has hemorrhoids and vaginal burning and has the Diclofenac at bedside for hip pain. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146043	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Manor Health Care	485 South Friendship Drive Nashville, IL 62263

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/6/24 at 11:18AM V10, Registered Nurse, (RN), stated, the care plan nurse watches residents to see if they are safe to have medications at bedside. V10 stated, she has no clue if they do an assessment for residents to have medications at bedside. V10 stated, residents can have medications in the dining room if a resident has an order. V10 further stated, there are no issues with residents bringing their medications from the dining room down the hallway in their wheelchairs if they have orders for medications at bedside. On 6/6/24 at 11:20am V3, Licensed Practical Nurse, (LPN), stated, the care plan nurse puts the orders in and deems the resident okay for medications at bedside. V3 stated she has not seen anyone taking their medication in their wheelchair down hall. On 6/6/24 at 3:12PM, V9, Minimum Data Set (MDS)/Care plan nurse, (LPN), stated, they do not have a comprehensive assessment that is reflected in their policy to assess residents' ability to have medication at bedside. V9 stated, she assesses a resident for cognitive awareness and physical mobility for self-administration of medication. V9 stated, R1 has ointment that she carries with her so she can apply it herself. V9 stated, R1 did not have a self-medication assessment. V9 stated they expect nursing supervision and oversight of medications especially if they are left in the dining room on tables for residents. On 6/6/24 at 1:43PM, V1, Administrator stated, the MDS nurse assesses the residents and makes sure they can read the labels, and the medical Doctor has to sign off the residents can have meds at bedside. V1 stated, she expects an assessment to be completed. V1 stated the aides are up and down hall and I would expect them to tell the nurse if a resident's medication was sitting at bedside. V1 stated, she expects nursing supervision and oversight of medications left for residents to administer, especially if the medications are left in the dining room unattended by staff on tables for residents to self-administer at a later time. 2. R7's Face sheet dated 6/6/24 documents, R7 was admitted [DATE] with a diagnosis in part of: unspecified dementia, Alzheimer's Disease with early onset, and epilepsy. R7's Brief Interview of Mental Status, (BIMS), dated 5/23/24 documents, R7 as severely cognitively impaired and requires supervision and set up for activities of daily living, (ADLs). R7's Care Plan dated 10/5/23 documents, focus area of cognitive deficient related to Alzheimer's, dementia: meds as ordered by physician, needs assist with direction to activity room and back, vision impairment, requires provided supervision with ADLs as needed related to weakness, 4/19/23: resident self-administers medications prepared by the nurse and left at bedside, quarterly review of independent abilities, review med with resident (when to take/apply and how much, review side effects with resident) R7's Physician Order Sheet, (POS), dated 5/6/24-6/6/24 does not document, an order for medications at bedside. R7's Self Administration Medication assessment dated [DATE] documents, R7's cognitive ability: full comprehension-yes, reliable yes/no answers-yes, unable to comprehend- no. Comments: medication may be prepared by nurse and left at bedside resident does understand how important her medication is. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146043	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Manor Health Care	485 South Friendship Drive Nashville, IL 62263

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's June 2024 Medication Treatment Record, (MAR), documents, R7 received metoprolol 24mg po, (orally), on 6/4/24 11:30. On 6/4/24 at 11:28am, V3, LPN was pulling up medications for R8. R7's medication cup with one pill in it remained on the top of the medication cart while V3 finished filling R8's medication cup. V3 took both R7 and R8's prepared medication cups to their shared tabled and left the R7 and R8's medications on their table. R7 did not touch or take medications until R7 received her lunch at 12:06pm. From 11:28am until 12:06pm, there was not continuous nursing observation of R7's medication that was on her table. On 6/6/24 at 3:12PM, V9, MDS/Care plan nurse, (LPN), agreed R7's Brief Interview of Mental Status (BIMS) assessment documented, R7 as severely cognitively impaired over the last 3 evolutions. V9 stated, R7 could follow simple commands but, that R7 had impairments and there was not a comprehensive self-administration assessment for R7. V9 stated, they expect nursing supervision and oversight of medications especially if they are left in the dining room on tables for residents. On 6/6/24 at 1:43PM, V1, Administrator stated, the MDS nurse assesses the residents and makes sure they can read the labels, and the medical doctor has to sign off the residents can have meds at bedside. V1 stated, she expects a comprehensive assessment to be completed. V1 stated, R7 can follow directions and is independent but agreed R7 had been assessed on her BIMS as severely cognitively impaired. V1 stated, they will redo the self-administration assessment. V1 stated, she expects nursing supervision and oversight of medications left for residents to administer, especially if the medications are left in the dining room unattended by staff on tables for residents to self-administer at a later time. 3. R8's Face sheet dated 6/6/24 documents, R8 was admitted [DATE] with a diagnosis in part of: unsteadiness on feet, localize edema, osteoporosis, diverticulosis, dizziness, and giddiness. R8's Brief Interview of Mental Status, (BIMS), dated 4/1/24 documents, R8 as cognitively intact and requires supervision and set up for activities of daily living, (ADLs). R8's Care Plan dated 10/5/23 documents, focus area of vision impairment, requires assist with ADLs as needed. The Care Plan but does not document self-administration of medication as part of R8's plan of care. R8's Physician Order Sheet, (POS), dated 5/6/24-6/6/24 documents an order for medications at bedside. R8's Self Administration Medication assessment dated [DATE] documents, R8's cognitive ability: full comprehension-yes, reliable yes/no answers-yes, unable to comprehend- no. Comments: medication may be prepared by nurse and left at bedside. R8's June 2024 Medication Treatment Record, (MAR), documents, R8 received Tylenol 500mg po, (orally), on 6/4/24 11:30. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146043	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Manor Health Care	485 South Friendship Drive Nashville, IL 62263

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 11:28am, V3, LPN was pulling up medications for R8. Another medication cup with one pill in it belonging to R7's remained on the top of the medication cart while V3 finished filling R8's medication cup. V3 took both R7's and R8's prepared medication cups to their shared tabled and left the R7's and R8's medications on their table. R8 did not touch or take medications until R8 at most of her meal at 12:21pm. From 11:28am until 12:21pm, there was not continuous nursing observation of R8's medication that was on her table. 4.R2's Face sheet dated 6/6/24 documents, R2 was admitted [DATE] with a diagnosis in part of: atrial fibrillation, weakness, anxiety, mild cognitive impairment, cognitive communication deficit. R2's Brief Interview of Mental Status, (BIMS), dated 4/1/24 documents, R2 as cognitively intact and requires moderate to maximal assist for activities of daily living, (ADLs). R2's Care Plan dated 3/6/2024 Vision Impairment r/t wears reading glasses: Resident requires the following visual aids: reading glasses; Res requires assist with ADL's r/t weakness, arthritis; Resident requires supervision/set up with meals. Provide finger foods when the resident has difficulty using utensils. Resident requires assistance of 1 with hygiene, clothing adjustment; Resident has dentures. Report changes to nurse. Resident requires 1 staff participation with mouth care. The Care Plan documents self-administration of medication after prepared by the nurse and left at the bedside. R2's Physician Order Sheet, (POS), dated 5/6/24-6/6/24 documents, an order for medications at bedside. R2's Self Administration Medication assessment dated [DATE] documents, R2's cognitive ability: full comprehension-yes, reliable yes/no answers-yes, unable to comprehend- no. Comments: medication may be prepared by nurse and left at bedside. R2's June 2024 Medication Treatment Record (MAR) documents R2 received Aspirin 81mg po, (orally), diltiazem 90mg po, Myrbetriq 50mg po, vitamin D 1.25mg po, calcium 600mg po, docusate sodium 100mg po, and ferrous sulfate 325mg po on 6/4/24 07:30. On 6/4/24 8:55 AM R2 was lying in bed and seven, (7), pills were in a medication cup on edge of bedside table. The medication cup was out of reach for R2. At this time, R2 stated, the nurse usually leaves them on the tray for her to take and they are not on that side of the table. 5. R3's Face sheet dated 6/6/24 documents, R3 was admitted [DATE] with a diagnosis in part of: bipolar disorder, weakness, malaise, depression, and need for assistance with personal care. R3's Brief Interview of Mental Status, (BIMS), dated 4/15/24 documents, R3 as cognitively intact and requires moderate assist to completely dependent upon staff for activities of daily living (ADLs). R3's Care Plan dated 5/22/2023 Vision Impairment, requires assist with ADL's. The Care Plan does not document self-administration of medication after prepared by the nurse and left at the bedside. R3's Physician Order Sheet, (POS), dated 5/6/24-6/6/24 does not documents, an order for medications at bedside. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146043	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Manor Health Care	485 South Friendship Drive Nashville, IL 62263

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Clinical Records did not reveal a Self-Administration Medication Assessment. On 6/4/24 at 9:09am, R3 was lying in bed, with breakfast tray in her room and breakfast almost completely consumed. R3 was confused and stated she had not had breakfast and asked for her tray. Diclofenac Sodium 1% topical gel was on R3's bedside table. The Facility's Policy Self-Administration of Medications undated, documents: Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including but not limited to the residents a. ability to read and understand medication labels, b. comprehension of the purpose and proper dosage and administration tie for his or her medications. 5. The staff and practitioner will document their findings and the choices of residents who are potentially capable of self-administering medications. 8. Self-administered medications must be stored in a safe and secure place, which is too accessible by other residents. Nursing will transfer the unopened medications to the resident when the resident requests them. 13. The staff and practitioner will periodically reevaluate a resident's ability to continue to self-administer medications.