STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165300	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laporte City Specialty Care	1100 Hwy 218 N LA Porte City, IA 50651

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents receive medications as ordered by the providers for 3 of 4 residents reviewed (Resident #1, #3 and #4). The facility failed to administer medications to the right resident when Resident #1 received Resident #2's morning (a.m.) medications. The facility failed to obtain orders to hold Lasix (diuretic medication) for Resident #1 after she received Resident #2's medications, which included blood pressure (BP) lowering medications. Resident #1 was transferred to the hospital for low blood pressure and was admitted to the Intensive Care Unit. The facility failed to give Resident #3 the correct dosage of his blood pressure medication, administering both a discontinued medication along with a newly ordered medication. The facility failed to administer insulin to the right resident when Resident #4 received another resident's insulin. Resident #4 did not have an order for insulin.The facility corrected the noncompliance prior to the start of the survey on 11/6/25 by completing the following:On 11/3, the Director of Nursing (DON) notified the Director of Agency Staffing of med error by agency nurse. Administrator informed that agency nurse received a final disciplinary warning regarding med error on this date and also received education regarding 7 Rights of Medication Administration and was audited the same day for oral administration. The facility conducted additional audits administration.On 11/3, Administrator confirmed with hospice that they provided education to both hospice nurses who assessed resident on 11/2. Education given regarding necessity to discuss medications with physician when reporting a med error specifically to determine if meds are to be given or held and methods to identify residents.On 11/5, the DON and Assistant DON provided nurses with education regarding 7 Rights of Medication Administration. Education also provided to nurses regarding necessity to discuss medications with physician when reporting a med error specifically to determine if meds are to be given or held and methods to identify residents.On 11/5, DON contacted physician provider regarding their process for inquiring about medications when a med error occurs. The physician provided added a workflow process for providers to specifically ask about med error and other medications.On 11/6, the DON applied Chart Label-Name Alert stickers for medication cards to further delineate that there is more than one resident with the same name.Effective 11/6, the DON and Assistant DON began conducting audits of charge nurses for medication administration twice per week on varying shifts for four weeks. They would provide re-education as necessaryThe facility reported a census of 45.Findings include:1. A Minimum Data Set (MDS) dated [DATE], documented diagnoses for Resident #1 included chronic kidney disease, anxiety, depression and senile degeneration of the brain (Senile degeneration of the brain refers to the progressive decline in cognitive function and brain health, often associated with aging and neurodegenerative disorders like Alzheimer's disease.). A Brief Interview for Mental Status (BIMS) documented a score of 3 out of 15, which indicated Resident #1 had severe cognitive impairment. the resident received antianxiety, antidepressant and diuretic medications. The MDS listed Resident #1 as dependent on staff for personal hygiene, putting on and taking off footwear, lower body dressing, toileting and oral hygiene. An Incident, Accident, Unusual Occurrence Note dated 11/2/25 at 7:00 a.m., documented that the author of the note (Staff A, Licensed Practical Nurse, LPN) asked Resident #1 if her name was (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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Resident #2's name. Resident #1 nodded her head. Staff A then administered the medications to Resident #1 instead of Resident #2. Later a Certified Nurse Aide (CNA) passed by. Staff A asked the CNA who was sitting next to Resident #1. The CNA gave the name of the other resident and then said Resident #1's full name. Staff A learned they gave the medications to the wrong resident. When Staff A found out the medications were administered to the wrong person, Staff A obtained vital signs. Staff A then notified Hospice, Resident #1's daughter, and the facility's provider. Staff A received a doctor's order to monitor Resident #1's blood pressure and pulse 4 times a day until HS (hour of sleep).A Hospice Note (Hospice Staff Use Only) dated 11/2/25 at 10:00 a.m., the author of the note (Staff C, Hospice Registered Nurse (RN)), documented that she made a PRN (as needed) visit due to a report she received regarding Resident #1 receiving the wrong medications that morning. Staff C assessed vital signs, spoke with the facility nurse and Staff A. Staff C told the staff of Resident #1's vital signs and directed to continue to monitor them per the provider's recommendations. Staff C called and left a voicemail with the family notifying them of the visit. An Incident, Accident, Unusual Occurrence Note dated 11/2/25 at 10:34 a.m., the author of the note (Staff B, LPN), documented that on the morning Resident #1 was given the wrong medication. The Hospice nurse came out to the facility and did an assessment. The Hospice nurse said Resident #1's BP was 99/60, her heart rate was 53, and the resident was doing well. The Hospice nurse said she would call the family about the situation.An Incident, Accident, Unusual Occurrence Note dated 12:50 p.m., Staff B documented she called Hospice back to notify them Resident #1's BP was low at 68/38. Staff B told the Hospice staff that Resident #1 received her morning medication late around 10:30 a.m. Staff B told Hospice that she received Lasix and the lorazepam medications. Staff B asked Hospice if Staff B should give these medications that were scheduled for lunch late, and they (Hospice) said to hold them due to the low BP and to pass on to the next shift to take blood pressure before giving any medication and use nursing judgement and hold if BP was below normal. Hospice also said to encourage Resident #1 to drink more fluids and that they would send the Hospice nurse on call back out to the facility.An Order Note dated 11/2/25 at 4:19 p.m., Staff F, LPN, documented she checked Resident #1's BP at 3:30 p.m., and it was 61/36 with a pulse of 46, respirations were 16. Staff F called the on-call provider and Staff D explained about the medication error the morning. The provider ordered Resident #1 to be sent to the ER (Emergency Room) for evaluation. Phone call placed to daughter who was in agreement. The nurse called the ambulance and sent Resident #1 to the ER for evaluation at 4:00 p.m. The nurse notified hospice.A Nurses Note dated 11/2/25 at 8:52 p.m., Staff F documented she called the ER, who informed her, they admitted Resident #1 to the ICU (Intensive Care Unit), for hypotension (low blood pressure) due to medications. Staff F notified the Assistant Director of Nursing (ADON).A Medication Administration Record for the month of November 2025, directed staff to administer the following medication to Resident #2 in the AM:Amlodipine 5 mg 1 tablet by mouth (po) for hypertension (high blood pressure)Aspirin 81 mg 1 tablet po for hypertensionFerrous Sulfate 1 tablet po 325 mg for anemiaIrbesartan 300 mg 1 tablet po for hypertensionMetoprolol 25 mg ER (extended release over 24 hours) 25 mg 1 tablet po for hypertensionZoloft 50 mg 1 tablet po for depression/anxietyFlecainide Acetate 50 mg 1 tablet po twice a day (BID) for coronary artery disease (CAD)Namenda 10 mg 1 tablet po BID for dementiaOn the morning of 11/2/25, Staff A, Licensed Practical Nurse (LPN), administered all of the above medications to Resident #1 instead. Staff A signed she gave them A Medication Administration Record for the month of November 2025, directed to administer the following medications to Resident #1 in the AM:Escitalopram 20 mg 1 tablet po for major depressive disorderLasix 80 mg po 1 tablet po to control edema Senna 8.6 mg 1 tablet for constipationAcetaminophen (Tylenol) 650 mg 1 tablet po for painLorazepam 2.5 milliliters (ml) po for anxiety.On the Record, it directed to administer Lasix 40 mg po 1 tablet to control edema mid-morning. Staff B did not give the medication. She put her initials in the space for 11/2/25 for the mid-morning dose with a 0. A Provider Order dated 11/2/25 at 8:00 a.m., directed staff to monitor blood pressure and pulse due to medication error 4 times a day until HS (hour of sleep).A Provider Order dated (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	11/2/25 at 4:30 p.m., directed staff to send Resident #1 to the ER (Emergency Room) for evaluation.Resident #1's Blood Pressure Summary Sheet documented the following on 11/2/25:8:00 a.m.: 99/56 mm/Hg (systolic (top number represents when your heart is beating) and diastolic (lower number represents when your heart is resting between beats)).10:33 a.m.: 99/60 mm/Hg12:22 p.m.: 68/39 mm/Hg1:29 p.m.: 70/40 mm/Hg3:15 p.m.: 61/36 mm/Hg the entry was struck through on 11/9/25 at 1:42 p.m. with incorrect documentation as the reason.Resident #1's Pulse Summary sheet documented the following on 11/2/25 at:8:00 a.m.: 47 bpm (beats per minute)10:33 a.m.: 53 bpm12:22 p.m.: 60 bpm1:29 p.m. 45 bpm3:15 p.m.: 46 bpmOn 11/19/25 at 11:49 a.m., Staff A stated that on the morning of the medication error, Resident #1 was not in her room and was out by the nurses' station. Staff A asked the resident her name and Resident #1 stated her first name. Staff A asked Resident #1 if her last name was Resident #2's last name and Resident #1 stated it was her last name. Resident #1 and Resident #2 have the same first name but different last names. No staff were close by to confirm Resident #1's identity. Staff A administered Resident #2's medications to Resident #1. A staff member walked by and Staff A asked the staff member if Resident #1 was Resident #2. The staff member said no. Staff A stated she then knew she had administered the wrong medications to Resident #1. Staff A called the facility's provider and the Hospice nurse. The facility's provider told Staff A to monitor Resident #1's vital signs (VS) every 4 hours. Staff B monitored Resident #1's VS. The Hospice nurse came in after breakfast around 9:00 a.m. Staff A asked the Hospice nurse if it was okay to administer Resident #1's morning medications (Resident #1 did not receive her own morning medications as she had received Resident #2's medication). The Staff C, Hospice RN/nurse said it was okay. When Staff A asked if she should have asked the doctor instead, Staff A said yes, that is correct. Staff A was the one that took Resident #1's VS. Staff A did the 8:00 a.m. set of VS. Staff A stated that when a resident is on Hospice, usually the Hospice nurse is the one who usually communicates with the doctor. The only doctor order Staff A obtained was to monitor Resident #1's VS. Then at noon the other nurse, Staff B, LPN, working called the Hospice number back while Staff A was on break. The Lasix (diuretic) was held because it could have caused the BP to lower more. After Staff A came back from break, Staff B got an order to hold the Lasix because Resident #1 had low BP when Staff B checked it around noon. It was Staff A's first time picking up at that facility. It was in the morning when Staff A got there, and the night shift nurse showed Staff A the medication cart and the medication room. Staff A stated it was getting close to 2:00 p.m., when Staff A finished up passing medications and then Staff A gave report to the 2nd shift nurse. That day Staff B did the assessments and treatments, while Staff A was supposed to do medication only. Staff A stated that normally Staff A only passed medications to 20 or so residents and there were like 40 residents to pass the medications. Staff A had to pass medications to all of the residents at the facility on that day. Staff A said she was not comfortable with that because there were a lot of residents. It was her first time at the facility, and she didn't know any of the residents. Staff A stated she was not going to do agency nursing anymore. On 11/19/25 at 12:18 p.m., Staff B stated she was doing the floor treatments, a few insulins, assessments, the facility's hot charting, and some skilled assessments. Staff B stated the second shift did the other assessments. How it worked is the charge nurse did all the medications and then the floor nurse does the floor treatments and assessments. The morning med pass has a lot more meds to administer than the lunch time med pass did. Staff B stated the facility had other nurses who have come in and passed medications and were able to do it, it is a lot. Staff B said she knows all of the residents and Staff B is not an agency nurse, so she knows it's easier for her to pass the meds. Staff B stated she has helped before when someone came in to fill in and said they needed help and Staff B helped them. It's hard to say if it was too much. There was an RN there for a little while that morning that stayed until 8:00 a.m. Staff B stated they trained a nurse on the floor that morning. After the med error, Staff A seemed flustered. Staff B stated she asked if she could help Staff A. Staff B stated she doesn't know if she was causing Staff A more frustration or if she was just upset about having the medication error. Staff B was concerned about giving Resident (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	#1 more Lasix as the resident's blood pressure was getting low, so Staff B called the hospice nurse about it. On 11/19/25 at 2:27 p.m., Staff C, Hospice nurse, stated the facility called a Hospice answering service. Staff C returned the call. Staff C stated that Resident #1 received the wrong medications administered by who Staff C thought was, a traveling nurse. The nurse, Staff A gave Resident #1 multiple BP medications. Staff C went into the facility. Staff C stated Resident #1 laid in bed alert and denied pain with no noted shortness of breath. Resident #1's BP was like 96 over something. Staff C let the nurse know she was there at the facility. Staff C told the nurse that Resident #1's VS were okay, and they weren't super low. Staff C stated she left a voice mail for Resident #1's daughter because nobody answered. Staff C stated Staff A asked if she should give Resident #1 her normal medications. Staff C stated she told Staff A that as long as there weren't any further BP or any diuretic medications, she felt it would be alright. Staff C stated she did not talk to anybody else after she left the building that morning. The only communication Staff C had with anybody at the facility was while she was there.On 11/20/25 at 12:16 p.m., Staff A stated that when she found out that she had given the wrong meds, she called the on-call provider, the hospice service and left a message for Resident #1's family. Staff A said Staff C came into the facility and said Resident #1 was fine. Staff A stated she had asked the Hospice nurse if Resident #1 should receive the medications that she should have gotten that morning. Staff A stated that she and Staff C then looked at the MAR and there was Lasix, Ativan, and Lexapro (antidepressant) that was not administered that morning. There was no discussion about calling the Hospice doctor. Staff C did not say anything about not giving diuretics or blood pressure medications, Staff C just said she didn't know why not to give Resident #1 the morning medications. Staff A gave the medications to Resident #1 around 10:30 a.m. Staff A said that later, after she had given Resident #1 the Lasix, Staff B, the floor nurse, did an assessment on Resident #1. Staff B stated that Resident #1's had low BP. Staff A stated Staff C ended up calling the Hospice service and the nurse Staff C talked to said to not give any more diuretics or blood pressure medications. On 11/19/25 at 2:50 p.m., Staff D, Hospice Nurse, stated she did not go into the facility. Staff D said she was just the hospice nurse that was on call. Staff C was the one who went into the facility. Staff D said that Staff A reported to Staff D that she gave the wrong medication to Resident #1 and they called Resident #1's daughter and left a message for her to call her back. Staff D stated that Resident #1 was admitted to the ICU that night. Staff D received a call from Staff B around the lunch hour. Staff B had said Resident #1's BP was 68/49. That's when Staff B told Staff D that Staff A went ahead and gave Resident #1 her other medication as well. Staff B wanted to know if she should give her Lasix and Staff D told her no. Staff D stated that after finding out later on that evening that Resident #1 was admitted to the ICU for a calcium channel overdose, Staff D call Resident #1's daughter because they couldn't provide services while in the ICU. Staff D stated she verbally called the daughter to revoke services. The daughter was upset, and she didn't understand how things like the could happen. Staff D stated she had not personally worked with Resident #1. When asked about telling Staff B to hold the Lasix, Staff D stated it was per nursing judgement to hold the medicine. She stated they can do that because Resident #1's BP was so low. On 11/20/25 at approximately 2:00 p.m., the Administrator and the Director of Nursing (DON) acknowledged the concerns with administering the wrong medications to Resident #1. They understood the concerns regarding Lasix being given after Resident #1 had received BP medications that she normally did not receive, as Lasix can lower the BP even more. They understood the need for Resident #1 being hospitalized after receiving the Lasix on top of all of the BP medications. The Administrator stated they had conversations with the nurses and the providers on how to prevent it from happening again.2. A MDS dated [DATE], documented diagnoses for Resident #3 included hypertension and orthostatic hypotension (drops in blood pressure when standing up from a sitting or lying position). A BIMS documented a score of 15 out of 15, which indicated intact cognitive functioning. A Medication Error report filled out by Staff E, LPN, dated 6/24/25, documented that Resident #3 received an additional dose of Metoprolol that a.m. The Nurse Practitioner was aware, (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	and they had stable VS. On 7/1/25, under Notes, it documented that staff education received education about following appropriate medication rights when passing medication. Assessment was given to the provider with new orders to complete vitals and monitor. A Medication Administration Record for the month of June 2025, directed staff to administer the following medication to Resident #2:Metoprolol 100 mg (metoprolol tartrate) take 1 tablet by mouth two times a day for atrial fibrillation (Afib)(irregular heart rhythm). The start date for the medication was 6/10/25 and the discontinue date was 6/23/25 at 4:32 p.m. Staff E signed the a.m. dose on 6/23/25. All other following doses were X'd out on the MAR leaving no place to sign.Metoprolol ER (extended release) (metoprolol succinate) give one tablet by mouth one time a day for Afib. The start date was 6/24/25 at 7:00 a.m. The discontinue date was 7/5/25. Staff E signed the a.m. dose on 6/24/25. A doctor's order dated 6/24/25 at 11:00 a.m., directed staff to check BP and heart rate every hour. Resident #3's Blood Pressure Summary sheet documented the following on 6/24/25 at:9:43 a.m.: 127/79 mmHg10:47 a.m.: 123/76 mmHg1:12 p.m.: 124/79 mmHg1:34 p.m.: 134/74 mmHg2:18 p.m.: 145/88 mmHg3:31 p.m.: 146/85 mmHg3:32 p.m.: 138/87 mmHg4:10 p.m.: 149/88 mmHgResident #3's Pulse Summary sheet documented the following on 6/24/25 at:9:43 a.m.: 90 bpm10:47 a.m.: 88 bpm1:12 p.m.: 82 bpm1:34 p.m.: 78 bpm2:18 p.m.: 77 bpm3:31 p.m.: 77 bpm3:32 p.m.: 81 bpm4:10 p.m.: 91 bpmAn Incident, Accident, Unusual Occurrence Note dated 6/24/25 at 1:23 p.m., documented that Resident #3 received an additional dose of metoprolol that morning. The Nurse Practitioner notified and ordered hourly vitals. Resident #3 was aware. Vital Signs are stable. Additional metoprolol card removed and sent to the pharmacy. On 11/19/25 at 1:10 p.m., Staff E, when asked about the above medication error, stated that if she remembered correctly it was put in the computer incorrectly. Staff E stated there was maybe a duplication in the orders. She said maybe it was a different type of Metoprolol. Staff E stated she thought she found out about it the next day and so Staff E thinks there were extra VS being done. After that medication error, to prevent another error like the one, they changed procedure and made it so that other nurses on the following shift after day shift would double check that all the new orders were done correctly. That old medications were pulled from the cart and that family notifications were done.On 11/19/25 at approximately 3:00 p.m., the DON stated that she thought the medication was changed to long acting and the old card did not get pulled so Staff E gave both the new and the old Metoprolol. 3. A MDS dated [DATE], documented that Resident #4 had a diagnosis of diabetes. It documented that Resident #4 had 0 insulin orders and that the resident received 1 insulin injection during the last 7 days. His BIMS score was 9 out of 15, which indicated moderately impaired cognition. A Medication Error Incident Report dated 5/2/25 at 11:00 p.m., documented that Resident #4 received a dose of 12 units of insulin that was not ordered. Resident #4 had diabetes and had a blood sugar of 138 at time of administration. The nurse called the provider who gave orders to check blood sugar every 15 minutes for 1 hour and then every hour for 4 hours after. At that time the staff didn't note any adverse reactions. The nurse notified the family and Resident #4 of the error. A Nurses Note dated 5/2/25 at 11:13 a.m., documented Resident #4 a dose of 12 units regular insulin in error at 11:00 a.m. The nurse called the provider, who provided a new order to check his blood sugar every 15 minutes for 1 hour and every hour for 4 hours after. No adverse events were noted at the time. Resident #4's Blood Sugar Summary Sheet documented the following on 5/2/25:11:14 a.m.: 138.0 mg/dL (glucose concentration in blood)11:25 a.m.: 118.0 mg/dL11:40 a.m.: 122.0 mg/dL11:55 a.m.: 123.0 mg/dL1:02 p.m.: 145.0 mg/dL1:58 p.m.: 138.0 mg/dL3:07 p.m.: 138.0 mg/dL4:08 p.m.: 129.0 mg/dLAll of the above blood sugars were checked by Staff B.On 11/19/25 at 10:55 a.m., Staff B stated it was a busy day that day. There were 2 residents that were new to her and they were right across the hall from each other. They had similar looks, similar body build, and similar names. Staff B went in and told Resident #4 that she was there to give him his insulin. Resident #4 said ?oh, okay' and lifted up his shirt. Staff B cleaned him with the alcohol wipe and gave him the shot. Staff B stated that Resident #4 was supposed to be alert and oriented per the report she had received. After Staff B gave Resident #4 the shot, Staff B went out to chart it, and that's when she noticed the room number (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	was different from his. Staff A stated she figured out she gave the insulin to the wrong resident. Staff A said she went back into his room and told him, she just gave him insulin, and she wasn't supposed to. Then Resident #4 yelled at her and said, ?you shouldn't have given me that I'm not a diabetic.' Staff B stated she checked his blood sugar prior to giving him the insulin and Resident #4 didn't say anything then either. Staff B said when she went out to document, she saw the room number and that is what cued her in. Staff B reported it right away to the Assistant Director of Nursing (ADON). They then notified the doctor and then she took his blood sugars several times per the provider's orders. Staff B called the wife too to let her know. Resident #4's blood sugar didn't drop low. Staff B stated she was told that he received insulin at the hospital prior to coming to the facility. Staff B said Resident #4 was alert and oriented and he knew what was going on. Resident #4 was at the facility for skilled care. The guy across the hall was here for skilled care too and they had both been admitted while Staff B was off work. On 11/20/25 at approximately 2:00 p.m., the Administrator and the DON acknowledged the medication error and understood the concern with giving insulin to a resident without an order for insulin.A Medication Administration policy revised April 2019, directed staff to administer medications in a safe and timely manner, and as prescribed. The Policy Interpretation and Implementation instructed Only persons licensed or permitted by the state to prepare, administer and document the administration of medications may do so.The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions.Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions.Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience.Factors that are considered include:Enhancing optimal therapeutic effect of the medication.Medications errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training.The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include:Checking photograph attached to medical record; andIf necessary, verifying resident identification with other facility personnel.The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.Vials labeled as single dose, or single use are not used on multiple residents. Such vials are used only for one resident in a single procedure.Insulin pens containing multiple doses of insulin are for single-resident use only. Changing the needle does not make it safe to use insulin pens for more than one resident.Insulin pens are clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the Nurse verifies that the correct pen is used for that resident.Post-exposure follow up procedures are conducted if an insulin pen is used for more than one resident.Medications ordered for a particular resident may not be administered to another resident, unless permitted by State law and facility policy and approved by the Director of Nursing Services.If a resident uses PRN medications frequently, the Attending Physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist as needed, shall reevaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated.New personnel authorized to administer medications are not permitted to prepare or administer medications until they have been oriented to the medication administration system used by the facility.The Charge Nurse must accompany new nursing personnel on their medication rounds for a minimum of three (3) days to ensure established procedures are followed and proper resident identification methods are learned.