

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235179	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/02/2024
NAME OF PROVIDER OR SUPPLIER  Christian Park Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 7th Avenue South Escanaba, MI 49829	

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)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>45123</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication administration error rate of less than five percent, with three errors identified out of 27 opportunities, affecting three Residents (R4, R5, and R207) of five residents observed for medication administration, resulting in a medication error rate of 11.11 percent. Findings include:</p> <p>On 10/1/24 at 7:36 AM, medication administration was observed with Registered Nurse (RN) A for R4. RN A was observed preparing and dispensing 13 pills for R4. RN A dispensed two cranberry 500 milligram (mg) with vitamin C 200 mg tab into the medication cup with the other 13 pills. RN A took them to R4 and R4 consumed all 13 of their medications prepared by RN A.</p> <p>On 10/1/24 at 7:40 AM, an interview was conducted with RN A, and was asked if she used the correct cranberry supplement for R4. RN A reviewed the order for R4, then looked at her stock cranberry supplement and replied, No, I guess not. RN A was asked if there was another stock cranberry supplement without the added vitamin C and proceeded to the medication supply room. RN A could not locate the correct stock supply medication for cranberry only.</p> <p>Review of R4's physician order, dated 9/26/24, revealed cranberry oral tablet 500 mg (cranberry Vaccinium macrocarpon, give 2 tablets by mouth one time a day for urinary tract health.</p> <p>On 10/1/24 at 8:00 AM, medication administration was observed with RN B for R5. RN B was observed preparing six medications for R5 at the medication cart. RN B popped out a metoprolol 100 mg tab out of a medication card when the medication fell on top of the medication cart. RN B picked up the metoprolol tab with her bare hands and placed it into the medication cup with the other medications she prepared for R5. RN B then walked to R5's room and gave them to R5 who consumed their medication.</p> <p>On 10/1/24 at 8:25 AM, medication administration was observed with RN B for R207. RN B was preparing an insulin glargine pen for R207. RN B failed to prime the insulin glargine pen and failed to clean the tip of the pen with an alcohol swab prior to adding a disposable needle tip.</p> <p>On 10/2/24 at 2:30 PM, an interview was conducted with the Director of Nursing (DON) who was made aware of the medication errors during medication pass. The DON replied, Nurses should be following the medication administration policy. If the policy does not cover specific medication administration types, then nurses are expected to follow the manufactures instructions for preparing and dispensing medications.</p> <p>(continued on next page)</p>

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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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the manufacture instructions for insulin glargine, read in part, .How to use your insulin glargine pen in 6 steps .Step 2. Wipe the pen tip (rubber seal) with an alcohol swab .Step 3. Dial a test dose of 2 units. Hold the pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more times .</p> <p>Review of policy titled, Medication Administration, dated 10/17/23, read in part, .Procedure: 1. Follow infection control practices .a. If medications come into contact with the bare hands of the nurse/QA med tech, or with the cart, the medication should be disposed of per policy and new medications obtained .2. Verify the medication label against the medication administration record for resident mane, time, drug, dose, and route .</p>		