

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Iron County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1523 U.S. Highway 2 Crystal Falls, MI 49920	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to incorporate the key components of staffing needs for each resident unit and staffing needs for each shift, into their facility assessment potentially affecting all 109 residents residing in the facility. Findings include: All times are in Eastern Daylight Time (EDT) unless otherwise noted. The facility assessment, last updated 2/12/2026, was reviewed. This document indicated the assessment was completed at the facility level to serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources. The section titled INFORMATION ABOUT NURSE STAFFING PLANS included a table with the heading of Overall Staffing Needs. Staffing positions were as follows: RNs (Registered Nurses) Providing Direct Care LPNs (Licensed Practical Nurses) Providing Direct Care RNs Available to Provide Direct Care (includes DON [Director of Nursing] and RNs with administrative duties Each position had an adjoining space for the number of staff needed titled Total Needed or Average or Range. These spaces were blank. The total number of each of the types of nurses had not been recorded. The next section of the Facility Assessment was titled Staffing Needs as per Resident Unit. The Staff Positions were listed, and next to each position was Ratio of Staff to Residents. The staff positions were RN, LPN, CNA (Certified Nurse Aide), Med Tech, Nurse Aide. Next to each position was See Attachment C for the ratio of staff to resident needed. The next section of the Facility Assessment was titled Staffing Needs as per Shift (adjust as needed). For the Staff Position of RN, LPN, CNA for each shift Nights, Days and Evenings again the Ratio of Staff to Residents column listed See Attachment C During an interview on 6/24/2026 at 11:57 AM, the Director of Nursing (DON) reviewed the facility assessment and staffing numbers. She presented and printed Attachment C which was one page and titled Staffing Numbers - CNA. Staffing numbers for RN or LPN were not found. During an interview on 6/24/2026 at 12:22 PM, the Assistant Director of Nursing (ADON) RN A discussed the calculated nursing needs. RN A said she calculated the CNA needs but said the nursing needs changed less and said, I do not calculate the nurse staffing needs. The Facility Assessment did not include licensed nurse staffing needs for each resident unit or each shift such as day, evening, and night.		

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. All times are in Eastern Daylight Time (EDT) unless otherwise noted. Based on record review and interview, low staffing was confirmed to have the potential to affect the entire facility population through review of reports by six Residents (#47, #50, #69, #80, #93, and one Confidential Resident [CR]) of six residents reviewed for staffing concerns. Findings include: The facility assessment, last updated 2/12/2026, was reviewed. This document indicated the assessment was completed at the facility level to serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources. The staffing needs for the facility were calculated in the facility assessment based on FTEs (Full Time Equivalents &ndash; or eight hours per day). The minimum and optimum need for Certified Nurse Aides (CNA) per shift was listed as follows: AM (day shift) MINIMUM TOTAL 13 and OPTIMAL TOTAL 19 PM (evening shift) MINIMUM TOTAL 13 and OPTIMAL TOTAL 19 NOC (night shift) MINIMUM TOTAL 7.5 and OPTIMAL TOTAL 14 The schedules for the past two weeks and past four weekends were reviewed and revealed: 5/29/26 evening shift schedule was blank on the posting and adequate staffing could not be determined 5/29/26 night shift schedule was blank on the posting and adequate staffing could not be determined 5/30/26 day shift schedule indicated only 11 FTE CNAs worked; 5/31/26 evening shift schedule was blank on the posting and adequate staffing could not be determined 6/20/26 day shift schedule indicated only 12 FTE CNAs worked; 6/21/26 day shift schedule indicated only 12 FTE CNAs worked; 6/21/26 night shift schedule indicated only 7 FTE CNAs worked; During an interview on 6/24/2026 at 11:57 AM, the Director of Nursing (DON) reviewed the facility assessment and staffing numbers. The posting sheets were compared to the actual worked staff schedules and found to be accurate. The discussion included staffing levels and the DON indicated she had been to the resident council several months ago and had heard concerns of not enough staff to meet the resident's needs. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/24/2026 at 12:22 PM, the Assistant Director of Nursing Registered Nurse (RN) A reviewed the staffing sheets and compared them to the facility assessment and stated, Yes that was a short day. The Hours per Resident Days were listed in the facility assessment and calculations revealed these numbers were not met on several of the examples presented. In conclusion the staff postings from the last 2 weeks and 4 weekends revealed 3 shifts were undocumented and 4 shifts were staffed under the assessed minimum needs of the facility as calculated and determined in the facility assessment. Review of document titled Resident Council Meeting dated 6/8/26, read in part .Call bells not being answered in a timely fashion .Resident currently stated that it depends on how busy the staff are.residents state they understand facility is short-staffed. During a group meeting on 6/23/26 at 3:43 p.m., Five Residents (#47, #50, #69, #80, and#93) of eight residents reported the following: Resident #47 stated, The facility is short staffed all of the time. Resident #50 stated, The facility is very short of staff. Resident #69 stated, I wish they could have more help.they need more staff here. Resident #80 stated, The facility is short staffed during the day. Resident #93 stated, The staff are shorthanded on the weekends. An interview was conducted with a Confidential Resident (CR) Designated Power of Attorney (DPOA) on 6/23/26 at 9:46 a.m. The DPOA for the CR stated they had concerns of the facility being short staffed, especially at nights. The DPOA stated the CR was new to the facility and prior to admission, the hospital stated they may not be able to send the resident to this facility due to short staff concerns.		

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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. Based on observation, interview, and record review the facility failed to properly label and store medications in 2 medication carts (200 Hall and 700 Hall) out of 3 medications carts observed. This deficient practice resulted in the potential for errors in medication administration and the potential for drug diversion. Findings include: On 6/23/2026 at 8:00 AM, an observation was made of the 700-unit medication cart left unattended with a clear cup of reddish liquid and a small medication cup with pudding and several different colors of crushed medication without a name or label on the cup. An interview was conducted with Licensed Practical Nurse (LPN) L who was asked if she oversaw the cart and replied, Yes. LPN L was asked if she knew whose medication was left on top of the medication cart and replied, I did not mean to leave them up there. They are for [Resident #17] I was going to give them to her, but she wanted to eat first. LPN L was asked if medications should be labeled with a resident name so she knows who they are if she gets interrupted or forgets and replied, Yeah, I should. LPN L removed the medications and put them in the third drawer of her medication cart without labeling them. On 6/23/26 at 1:20 PM, an observation was made of the 700-unit medication cart unattended with a small medication cup on top of an apple sauce with approximately 15 ml (milliliters) of white liquid without a label. LPN L was observed behind a close door of the nurses' station. LPN L was asked to come out for an interview and was asked why the medication was left, what it was, and who it was for and replied, It is for [Resident #76] and it is Mylanta. She requested it because her stomach is upset and I haven't given it to her yet. I should not have left it on top of my cart. My bad again. Review of R76's medical records, unveiled an order dated 7/3/24, Geri-Lanta Suspension. Give 10 ml by mouth every 4 hours as needed. On 6/23/26 at 4:50 PM, an interview was conducted with the Director of Nursing (DON) who was asked about medications being left on top of the medication cart, unattended, and not labeled and replied, The medications should have been discarded in the drug buster. If a resident does not want their medications at the time of dispensing, they are discarded. Medications are not to be left unattended, left of the top of the medication cart, or not labeled as to what or who they are for. On 6/24/26 at 9:40 AM, an interview was held with the Nursing Home Administrator (NHA) who was made aware of the medication storage concerns and replied, Pharmacy just went through the carts last week and said they were great. Wallets should be kept behind the nurses' station and not in the medication carts and medications need to have a residents name on them. Review of policy titled, Medication Administration, dated 4/17/24 read in part .Purpose: To ensure that a procedure exists for the proper and safe administration of resident medications following Physician orders.Procedure: Medications will be administered per MD [medical doctor] orders.A. Oral (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medications.21. If resident refuses medications, document in the EHR [electronic health record] and notify Charge Nurse. If medication has been prepared and it is then refused, destroy in Drug Buster. Review of policy titled, Storage and Expiration of Medications, Biologicals, Syringes, and Needles, dated 5/5/23 read in part .Purpose/Policy: To ensure proper storage of medications.Procedure.3. General Storage Procedures.c. ICMCF should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. Observation of the 200/300 hall medication cart on 6/24/26 at 8:30 a.m., with Licensed Practical Nurse (LPN) G, found a small, unlabeled glass bottle filled with small nitroglycerin tablets, in the right side, locked compartment of the narcotic drawer, along with two wallets, two pair of eyeglasses and their cases, and an unidentified key on an antler keychain. Both wallets contained money with no documentation of the amount of funds contained within the wallets. During an interview on 6/24/26 at 8:47 a.m., Registered Nurse (RN) Supervisor F, returned to the 200/300 hall medication cart and retrieved the two wallets, two pairs of glasses and set of keys. RN Supervisor F observed the nitroglycerin bottle, confirmed it was unlabeled, and stated, We would not use this (to administer to a resident), we would use our own (medication). RN Supervisor F acknowledged the wallets, glasses and keys should not be stored in the locked, right side narcotic drawer with unlabeled medication. Review of the [Facility Name] Storage and Expiration of Medications, Biologicals, Syringes, and Needles policy, effective 10/8/20, revealed the following, in part: .[Facility Name] should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors . [Facility Name] should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels .		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. All times are noted in Eastern Daylight Time unless otherwise noted. Based on observation and interview, the facility failed to maintain two exterior doors and one interior door, resulting in an increased potential for pest infestation and a possible decrease in satisfaction of living for residents. Findings Include: On 6/23/2026 at 1:25 PM daylight was observed coming in under the exit door #20 in the Skyway Basement, and the door sweep was missing from this door. During this observation, Maintenance Director (MD) D agreed that daylight was visible under this door and stated the door sweep needed to be replaced and that these entry doors received a lot of use, resulting in wear and tear. On 6/23/2026 at 1:34 PM the exterior door on the 200 wing vestibule was observed and had a door sweep that was damaged with a quarter inch space observed between the door and the door jamb, allowing daylight to be visible under the door. Also observed the door sweep missing from the interior door, with an approximate half inch space between the door and the threshold, allowing daylight to be visible under the door. During this observation, MD D stated that these door sweeps received a lot of wear and tear and needed to be replaced.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** All times are in Eastern Daylight Time (EDT) unless otherwise noted. Based on observation, interview, and record review, the facility failed to implement fall prevention interventions for one Resident (#29) after an identified root cause to prevent subsequent falls and failed to adhere to care planned interventions to prevent hot liquid spills for one Resident (#89) of four residents reviewed for accidents and supervision. Findings include: Resident #29 (R29) On 6/3/26 at 11:03 AM, R29 was observed seated in a wheelchair in their room. A power lift recliner equipped with a remote control was positioned adjacent to the resident's bed. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R29's most recent admission date as 3/9/26. The MDS coded R29 with severe cognitive impairment, dementia, anxiety disorder, and a history of falls since admission. A progress note dated 1/29/26 at 3:26 PM documented concerns regarding the unsafe use of the power lift recliner by R29. The note indicated R29 was unable to consistently position the chair safely and repeatedly reclined the chair while eating despite repeated staff education regarding aspiration risk and unsafe positioning. The note read, in part: .Writer contacted resident's DPOA [Durable Power of Attorney] [name redacted] to update him regarding ongoing concerns with resident's use of power recliner. Resident has demonstrated unsafe operation of recliner remote, including inability to consistently position chair safely. Resident has also continued to recline chair while eating meals, despite repeated staff education regarding risk of aspiration and unsafe intake when reclined. The electronic medical record (EMR) documented on 4/4/26 at approximately 1:20 PM, R29 experienced an unwitnessed fall. Staff responded after hearing the resident calling for help and found R29 lying on her back on the floor with the recliner fully reclined. R29 was in the power lift recliner prior to being found on the floor. Documentation identified the suspected cause of the fall as activation of the recliner remote control, resulting in unsafe positioning of the chair and the resident sliding to the floor. The investigation further identified contributing factors including impaired safety awareness related to cognitive deficits and the resident's access to the recliner remote control. The associated incident report documented the care planned intervention as reminding the resident regarding proper operation of the recliner controls, instructing the resident to use the call light for staff assistance with repositioning, and obtaining a risk-versus-benefit agreement from the family. The incident report read, in part: .We have tried to move the control [recliner remote control] but resident must have access to controller as to not be restrained. So will remind resident on proper use of controls and utilizing call light for staff to assist when needing to reposition. Family to sign risk vs. [versus] benefits form . The fall care plan of R29 contained an intervention dated 4/22/26 that read: The risk vs benefit of me (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	using my remote control have been discussed with family and resident. Although deemed unsafe to use, family and resident prefer to keep the remote within my reach. A Risk vs. Benefit Form completed on 4/14/26 documented the primary safety concern as Recliner Remote Control & falls. The assessment identified generalized weakness, impaired judgment due to cognitive impairment, poor trunk control, impulsivity, poor safety awareness, and a history of falls. The assessment further concluded that continued access to the recliner remote control presented a high likelihood of unsafe chair positioning leading to sliding from the chair, loss of balance due to trunk and leg weakness, impulsive activation without staff supervision, and an increased risk of falls with injury. Further review of the EMR disclosed that despite the facility's identification of the root cause of the fall and acknowledgment of R29's inability to safely operate the power recliner, the facility did not implement additional interventions designed to eliminate or substantially reduce the identified hazard. The facility continued to rely on verbal reminders and education for a resident assessed with severe cognitive impairment and impaired safety awareness. During an interview on 6/24/26 at 10:56 AM, the Director of Rehabilitation (DOR) stated Resident #29 used the power lift recliner almost daily and had undergone multiple therapy assessments because of ongoing safety concerns with the power lift recliner. The DOR stated R29 had consistently been determined to be unsafe in the power lift recliner and acknowledged, She is not safe to be in that chair. The DOR agreed that the continued exposure of R29 to the same known and foreseeable accident hazard that had previously resulted in falls increased the risk of future falls from the recliner with risk of injury to the resident. The policy titled Fall Response Policy and Procedure dated 9/23/21 read, in part: .the Risk Manager/Designee will review fall paperwork and ensures he/she:. Meets with the resident/staff if able and discusses the fall and root causes. Together they update interventions and changes to plan of care and Kardex to reduce the risk of repeat falls of the same nature. Within one week from the date of the fall, the Risk Manager/Designee reviews and completes the Fall Investigation Form to verify the root cause of the fall and ensure appropriate interventions are in place. Resident #89 (R89) Review of R89's EMR revealed admission to the facility on 1/16/25 with diagnosis including dementia, rheumatoid arthritis, and muscle weakness. R89's Quarterly MDS assessment dated [DATE] revealed she scored a 8/15 on the Brief Interview for Mental Status (BIMS) score, indicative of moderate cognitive impairment. On 6/23/2026 at 10:46 AM During breakfast observation, R89 was observed with a coffee cup with no lid sitting at the breakfast table. R89 was holding the cup with their left thumb and index finger and R89 was observed appearing to be falling asleep at the table. R89 then subsequently spilled coffee onto her lap and woke up. Staff assisted R89 and stated that the coffee was cold. On 6/24/2026 at 8:44 AM, R89 was observed at breakfast with a cup of coffee and no lid. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/2026 at approximately 12:10 PM, R89 was observed sitting at the table with a cup of coffee without a lid. R89's meal ticket was observed next to them, which read, 8 oz Coffee-Regular-Cream with EZ Lid. An interview was conducted with Resident Assistant/Staff N on 6/24/2026 at 12:15 PM. Staff N stated this was only her second day on the floor and did not know to provide R89 with an EZ Lid for her coffee. Staff N stated she did not read R89's ticket tray. Review of R89's Care Plan, read, in part, Offer me my adaptive equipment of EZ lids for my coffee per my preference. Date Initiated: 01/16/2026 Created on: 01/16/2026 An interview was conducted with the Director of Nursing (DON) on 6/24/2026. The DON confirmed that R89 should have a lid for her hot coffee. Review of the facility's Hot Liquid Safety Policy dated 6/5/2025 read, in part, Hot liquids are to be served at proper (safe and appetizing) temperatures using appropriate safety precautions .All residents are assessed for their ability to handle containers and consume hot liquids. Residents with difficulties will receive appropriate supervision and use of assistive devices to consume hot liquids. Interventions will be individualized and noted on the resident's plan of care and on the closet Kardex sheet .EZ Sip Lids will be kept available wherever coffee is served .		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. All times are noted in Eastern Daylight Time unless otherwise noted. Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was stored in a clean and sanitary manner between resident use for three Residents (#20, #48, & #71) of three residents reviewed for respiratory care. Findings include: Resident #20 (R20) An observation made on 6/23/26 at 8:18 AM, of R20's room and oxygen equipment. R20's oxygen tubing was dated 6/11/26 and not stored in bag but draped over the oxygen concentrator with the nose piece exposed. R20 also had a bubbler attached to his oxygen concentrator dated 6/11/26. On 6/23/26 at 8:20 AM, an interview was conducted with Licensed Practical Nurse (LPN) L who was asked how often respiratory equipment is changed and replied, I think the tubing is changed weekly and dated. I am not sure about the bubbler/humification. LPN L was asked what the process was if the oxygen tubing is not in use and replied, If the tubing is not being used it is stored in a bag attached to the machine for infection purposes. LPN L confirmed R20's oxygen tubing was not stored properly in a bag and should have been changed last week. Review of R20's medical record on 6/23/26 at 8:25 AM, revealed a physician order dated 5/6/26 Oxygen at 2L [liters] via nasal cannula PRN [as needed] to maintain sats >90%. Resident #48 (R48) On 6/23/26 at 8:35 AM, an observation was made of R48's respiratory equipment. R48's oxygen humidification container was dated 6/11/26 and the nasal cannula was draped over their oxygen concentrator not stored in a bag. An observation made on 6/23/26 at 4:10 PM, of R48's room and oxygen equipment. The observations remained the same with a date of 6/11/26 on the oxygen tubing which was left unbagged and draped over their oxygen concentrator. Review of R48's medical record on 6/24/26 at 9:30 AM, revealed a physician order dated 5/12/25 Oxygen therapy if needed. Resident #71 (R71) On 6/23/26 at 9:14 AM, an observation was made of R71's oxygen concentrator tubing dated 6/4/26 and bubbler dated 6/11/26. An observation was made on 6/23/26 at 4:12 PM, of R71's oxygen equipment. Staff had not changed out and bubbler dated 6/11/26 or the tubing dated 6/4/26 which was draped over their oxygen concentrator. Review of R71's medical record on 6/23/26 at 9:35 AM, revealed a physician order dated 5/26/26 Obtain oxygen sat every shift: Place PRN oxygen to keep sats above 90%. 2L via nasal cannula. On 6/23/26 at 2:40 PM, an interview was conducted with the Director of Nursing (DON) regarding oxygen tubing and care of equipment. The DON indicated bubblers were supposed to be changed weekly, dated and any breathing/oxygen delivery device needed to be stored in a bag and not draped over the oxygen concentrators. Review of policy titled, Oxygen Use and Set-up, dated 4/30/25 read in part, .Purpose: Oxygen is administered to residents who need it consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Procedure.6. O2 tubing on concentrator will be changed every 2 weeks and PRN. O2 humidifier bottles on the concentrator will be changed weekly and PRN.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. All times are noted in Eastern Daylight Time unless otherwise noted. Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% involving one Resident (#48) of three residents reviewed for medication administration, resulting in a medication error rate of 6%, with 2 errors out of 31 opportunities. Findings include: On 6/23/26 at 8:05 AM, an observation was made of Licensed Practical Nurse (LPN) L preparing medication pass for Resident #48 (R48) which included oral, subcutaneous (under the skin), and ophthalmic (eye) medications. LPN L was observed priming two units from the insulin pen while holding the pen horizontally. Error #1: LPN L was made aware she needs to prime the insulin pen holding it upward (vertically) and watch for insulin to expel from the end of the needle. Error #2: On 6/23/26 at 8:50 AM, an observation was made of LPN L administering R48's eye drops by placing one drop in her right eye. R48's right eye drop was observed to run down her cheek. LPN L then placed three drops in R48's left eye. R48's left eye drops were observed to run down her left cheek. LPN L took a tissue and wiped both of R48's eyes. LPN L failed to hold the inner canthus (inner corner of the eye) of R48's eyes gently for one minute to promote absorption and reduce any potential systemic (elsewhere in the body) effect. Review of R48's physician orders, dated 12/24/25 read in part Lantus Solostar 100 unit/ml [milliliter] (3ml). Inject 18 units subcutaneously one time a day. and Systane Ultra Ophthalmic Solution. Install 2 drop in both eyes two times a day. An interview was conducted with LPN L on 6/23/26 at 1:30 PM and was asked how to administer eye drops and replied, You have to hold for three minutes. LPN L was made aware she should have held each eye for one minute and administer the drops inside the lower conjunctival sac (eye lid pocket). On 6/23/26 at 2:45 PM, an interview was held with the Director of Nursing (DON) who was made aware of the medication error rate and stated, Eye drops are to be held for a minute after administration of each eye and insulin pens need to be primed holding the pen upright. Review of policy titled, Medication Administration, dated 4/17/24 read in part .Purpose: To ensure that a procedure exists for the proper and safe administration of resident medications following Physician orders. Procedure: Medications will be administered per MD [medical doctor] orders. The Licensed Nurse is to read the EMAR [electronic medication administration record], follow the 7 rights of drug administration. right dose. F. Eye drops/Ointments. b.) Compare the label with the order to verify correct medication, dose, route, and time of administration. 4. Position resident with head tilted back. c.) With other hand, pull down lower eyelid to form a pouch of the conjunctival sac, instructing resident to look up. g.) Instruct resident to close eyes slowly to allow for even distribution over the surface of the eye and apply gentle pressure to the tear duct for one minute or by gently closing the eye for 3 minutes. K. Insulin. 8. Prime the insulin pen: a.) Dial 2 units by turning the dose selector clockwise. b.) With the needle pointing up, push on the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears.		