

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Carriage Inn of Cadiz		STREET ADDRESS, CITY, STATE, ZIP CODE 308 West Warren Street Cadiz, OH 43907	
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 - Many	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** Based on observation, record review, and interview, the facility failed to provide safe and secure medication storage, including proper labeling and maintaining temperatures of medication storage refrigerators, of all medications. This had the potential to affect all residents of the facility. The facility census was 51. Findings include: On 12/09/2025 at 9:05 A.M., an observation of the treatment cart in the Kerrozin medication room was performed. The observation revealed Medihoney 1.5-ounce tube which was opened, unlabeled, and undated. The treatment cart observation further revealed a Dermasyn hydrogel wound dressing 3-ounce tube which was opened, unlabeled, and undated. This was confirmed by Registered Nurse (RN) #179 at the time of the observation. On 12/09/2025 at 9:20 A.M., an observation of the medication refrigerator in the medication room of [NAME] Hall revealed the refrigerator held medications and vaccinations for residents. The temperature of this refrigerator was noted to be 60 degrees Fahrenheit (F). This was confirmed at the time of observation by RN #174. On 12/09/2025 at 10:19 A.M., a second observation of the medication refrigerator in the medication room of [NAME] Hall held Aplisol, Humalog Kwik Pens and Lantus Solostars, among other medications. Further, this observation revealed the refrigerator temperature was noted to be 50 degrees F. This was confirmed at the time of observation by Licenses Practical Nurse (LPN) #152. A review of storage instructions revealed Aplisol (tuberculin testing agent) should be stored in the refrigerator between 36- and 46-degrees F. Lantus Solostar (long-acting insulin pen) should be stored in the refrigerator between 36 degrees and 46 degrees F until it was opened. Review of storage instructions for Humalog Kwik Pen (Insulin pen) revealed the pen should be stored in the refrigerator between 36- and 46-degrees F until opened. Review of a facility form titled, Temperature Log for Refrigerator located on the [NAME] Hall medication room refrigerator, revealed twice daily temperatures for the month of December 2025. On 12/07/25, there was a temperature marked above the 46 degrees at 6:00 A.M., however no actual temperature was noted. The log revealed a temperature of 45 degrees on 12/09/25 at 6:00 A.M. This form had a section for Danger! Temperatures above 46 degrees F or below 36 degrees F are out of range. If found, write these temperatures and room temperatures below. The contents of this form were confirmed by LPN #152 on 12/09/25 at 10:23 A.M. Review of a facility policy titled, Medication Storage, dated 04/06/24 and updated 12/09/25, revealed all medications housed at the facility would be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. The policy indicated temperatures for medications requiring refrigeration were stored in refrigerators located in the pharmacy and each medication room. Temperatures were to be maintained between 36-46 degrees F. This was to be documented daily on the log by the charge nurse. In the event the refrigerator malfunctioned, the Maintenance Department would be contacted immediately.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on review of the facility's infection control surveillance logs and interview, the facility failed to adequately monitor for patterns of infection and provide oversight to identify the cause of identified patterns of infection. This had the potential to affect all 51 residents. Findings include: Review of the July 2025 infection surveillance logs revealed six residents had urinary tract infections (UTI), with Resident #7 being treated twice for UTI. The surveillance logs did not contain information regarding what microorganisms were involved. Review of the August 2025 infection surveillance records revealed microorganisms were not monitored. During an interview with Registered Nurse (RN)/Infection Control Preventionist (ICP) #102 on 12/11/25 at 12:13 P.M., RN #102 verified when tracking for patterns of infection, she did not monitor the microorganisms involved. RN #102 stated there had been an increase in UTIs during the summer. There was no documented plan/course of action. RN #102 stated there had been an increase in fluids provided and staff had been educated regarding perineal care. However, upon review of education records, RN #102 verified the only records she had related to hydration was dated 02/28/25 and there was no education provided related to perineal care/incontinence care since the pattern was identified in July 2025. RN #102 stated the topics were addressed during an annual education day but no records were provided. In addition, during an interview of RN #102 on 12/11/25 at 1:04 P.M., RN #102 stated there had been no audits specific to infections. After the pattern for increased UTIs was identified in July 2025, no audits of perineal/incontinence care or handwashing were completed to determine if they contributed to the increase in UTIs. RN #102 stated she was part of the Quality Assurance (QA) team and she was responsible for reporting on antibiotic use to enable the QA team to determine if any action needed taken. As part of the report, she did not address how many of the infections actually met criteria for antibiotic use.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of infection surveillance records, policy review and interview, the facility failed to ensure antibiotic orders were thoroughly researched to determine if residents met the criteria for infections, failed to ensure when criteria was not met the prescriber was informed, and failed to provide education and reports regarding antibiotic use to prescribers in accordance with policies. This affected three (Residents #7, #21 and #61) of four residents reviewed for antibiotic use and had the potential to affect any other residents for whom antibiotics were ordered. During review of the August 2025 infection surveillance reports, the following were identified: 1. Review of Resident #7's medical record revealed diagnoses including secondary Parkinsonism, irritable bowel syndrome, and dementia. A nursing note dated 07/21/25 at 11:00 P.M. indicated new orders were received for a Complete Blood Count (CBC) and a Comprehensive Metabolic Panel (CMP) to be obtained the morning of 07/22/25 and telehealth was requesting a urine sensitivity report. The hospital lab reported a culture and sensitivity was unable to be completed from the urine sample collected 07/18/25 as a culture and sensitivity was not ordered. A new urine sample would need obtained. On 07/22/25, an order was received for Bactrim DS (antibiotic) 800-160 milligrams: one tablet twice a day for Urinary Tract Infection (UTI) until 07/27/25. Review of an infection report form revealed the criteria for UTI was not met. A notation dated 07/24/25 revealed the urinalysis and culture results were sent to a covering physician. The antibiotic was to continue. The log revealed Resident #7's infection had carried over from the July infection surveillance. An infection report form indicated Resident #7 returned from the hospital on [DATE] with a diagnosis of Urinary Tract Infection (UTI). The evaluation for whether the antibiotic use met UTI criteria was blank. Notes indicated the physician reviewed medications and confirmed he wanted the antibiotic continued. During an interview with Registered Nurse (RN)/Infection Control Practitioner (ICP) #102 on 12/11/25 at 12:13 P.M., RN #102 stated when she contacted the physician regarding continuing the antibiotic on 07/24/25, she did not recall informing the physician that Resident #7 did not meet the criteria of UTI. RN #102 reported when Resident #7 returned from the hospital on [DATE] she was already diagnosed with a UTI. RN #102 verified she did not check to see if the criteria for infection was met. There was no evidence this was discussed with the attending physician who decided to continue the antibiotic. 2. Review of Resident #61's medical record revealed diagnoses including Congestive Heart Failure (CHF) and hypertension. Review of an infection report form revealed under the area to evaluate for UTI a notation to see report. The report indicated Resident #61 did not meet the criteria for UTI. A notation on 08/04/25 revealed the physician had reviewed medications ordered upon admission on [DATE] and decided to continue antibiotics as ordered by the hospital. On 12/11/25 at 1:04 P.M., RN #102 verified Resident #61 did not meet the criteria for UTI on 08/01/25. RN #102 did not contact the physician about the criteria for UTI not being met as he had already reviewed medication orders. 3. Review of Resident #21's medical record revealed diagnoses including chronic obstructive pulmonary disease and anxiety disorder. Review of an infection report form indicated Resident #21 met one of the two criteria for UTI (culture results). However, the evaluation indicated criteria was met. Cefuroxime Axetil (antibiotic) 500 mg was ordered twice a day by mouth for ten days on 08/17/25. On 08/25/25, an order was received to change the Cefuroxime Axetil to ceftriaxone sodium (antibiotic) one gram intramuscularly at bedtime for seven days. On 12/11/25 at 1:04 P.M., RN #102 verified based on the information she had available, criteria for UTI was not met. Because she had assessed that criteria was met she would not have communicated otherwise to the physician. 4. Review of the facility's Antibiotic Stewardship Program policy, reviewed/revised 12/08/25, revealed at least annually or per facility policy, each attending physician should be provided feedback on his/her antibiotic use data in the form of a written report to improve prescribing practices and resident outcomes. Education regarding antibiotic stewardship should be provided at least annually to facility staff, prescribing practitioners, residents and (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	families.On 12/11/25 at 12:55 P.M., RN #102 stated she did not do annual training of physicians on antibiotic stewardship and did not provide an annual report/feedback to physicians on antibiotic use. RN #102 stated during quarterly Quality Assurance (QA) meetings she provided reports regarding the frequency of antibiotic use. The medical director was present at those meetings. The reports did not include information regarding how often antibiotics were utilized when criteria for infection was not met.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on review of medical records, activity calendars, activity logs, facility policy, and interviews with staff and residents, the facility failed to maintain an activity program specific to meet the individualized needs of Resident #40. This affected one resident (Resident #40) of one resident reviewed for the activities program. The facility census was 51. Findings include: Record review of Resident #40 revealed admission to facility on 01/23/25 for diagnosis including encephalopathy (fluid on the brain) adult failure to thrive, depression, moderate protein-calorie malnutrition, surgical after care for large tumor removal to abdomen on 7/8/25, insomnia (inability to sleep), anemia (low blood counts), Alzheimer's disease, dementia (confusion and forgetfulness) with moderate mood disturbances. Review of Resident #40 Minimum Data Set (MDS) quarterly assessment completed on 10/04/25 revealed a Brief Interview for Mental Status score of 4/15 indicating severe cognitive deficit (impaired memory and confusion). Further review of the MDS revealed inattention and disorganized thinking that fluctuates. Resident #40 needed set up or supervision assistance with personal care and bathing. Review of the most recent annual comprehensive MDS assessment revealed the activities and individual preferences section was not answered. Review of the care plan, most recently revised on 10/07/25, revealed Resident #40 enjoys spending time in garden and listening to music. Review of care plan further revealed Resident #40 has little involvement in activities. Interventions included but not limited to encourage the resident to participate in activities that will stimulate mental functioning, invite/escort to activities of interest, provide 1:1 visits as needed, provide activity calendar, provide items needed for self-directed activities as indicated, individual activity of choice. Observation on 12/08/25 at 10:00 A.M. revealed Resident #40 was in room alone and unable to elaborate on activities that she participates in. There was no television or music on. Observation on 12/08/25 at 2:40 P.M. revealed Resident #40 up walking around independently in her room. No music or television was on. Observation on 12/09/25 at 8:57 A.M. revealed Resident #40 sleeping on ride side at bottom of bed, with no music or television on. Observation and interview on 12/09/25 at 2:44 P.M. revealed Resident #40 was sitting up in bed dressed and groomed and you could hear bingo being played down hall. Resident #40 denied interest in playing bingo and declined to go to the activity. Resident #40 further reported most of the activities do not interest her. There was no television or music on. Observation and interview on 12/10/25 at 2:46 P.M. revealed Resident #40 lying in her bed. Resident #40 revealed she did not want to participate in the Christmas ornament making activity. Further observation revealed a flowered blanket that Resident #40 stated her son had brought her and that it would look nicer with some flowers in her room. There was no television or music on. Observation and interview on 12/10/25 at 3:24 P.M. revealed Resident #40 was still not interested in activity. The daily chronicle paper, coloring page, and crossword puzzle were present on bedside table not completed. There was no television or music playing. Observation on 12/10/25 at 4:35 P.M. revealed Resident #40 sleeping in bed with lights out. Observation on 12/11/25 at 9:32 A.M. revealed Resident #40 lying in bed awake looking at wall. There was no music or television on. Review of monthly activity calendars for October, November, and December 2025 revealed a daily coffee cart at 10:00 A.M. and then a daily activity scheduled at 2:00 P.M. Bingo was noted to be the 2:00 P.M. activity twice a week and some Saturdays. There were 4-5 music related activities scheduled for each month. There were no gardening or flower type activities noted for October, November, or December. Review of the monthly activity participation logs for August, September, October, November, and December of 2025 revealed in August 2025 Resident #40 participated in 8 activities in which 4 were related to music, in September 2025 Resident #40 participated in 5 activities in which 3 were music related, in October 2025 Resident #40 participated in 7 activities which 4 were music related, November 2025 Resident #40 participated in 7 activities which 4 were music related, and Resident #40 had participated in 3 music related activities for December 2025. There were no activities logs for any 1:1 activities or independent activities. Interview (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 12/09/25 at 3:24 P.M. with Activities Director (AD) #101 revealed Resident #40 was on a handwritten list for residents needing 1:1 interaction due to self-isolation. AD #101 confirmed Resident #40 declines most activities and it was hard to coax into leaving her room. AD #101 further revealed Resident #40 will sometimes come to her doorway or stand near nurses' station when facility has music events. AD #101 reported that Resident #40 does show interest in music activities. AD #101 further reported that a coffee cart is brought up from the kitchen every day at 10:00 A.M. and the activity aides pass out coffee to each resident in their rooms along with three handouts, The Daily Chronicle, a coloring page, and a daily word search. AD #101 reports Resident #40 always accepts coffee. Continued interview revealed AD #101 reported having a tablet to set up face time calls with Resident #40 daughter but they were having issues with the password and haven't called her daughter yet to get it working. AD #101 confirmed there were not documented notes in the medical record or in the activity logs of any 1:1 activities or independent activities being completed with Resident #40. Interview on 12/10/25 at 4:17 P.M. with Certified Nursing Assistant (CNA) #125 revealed Resident #40 has been more withdrawn since the passing of her room mate three weeks ago. CNA further reports that Resident #40 rarely participates in activities despite encouragement. Interview on 12/10/25 at 4:30 P.M. with Registered Nurse (RN) #138 revealed Resident #40 doesn't really participate in activities and rarely leaves her room. Interview on 12/11/25 at 9:35 A.M. with RN #167 revealed that Resident #40 can be difficult to engage and get out of her room. RN #167 denied knowledge of any special interests of Resident #40 but reported she does like the music entertainers when they come to the facility. Interview on 12/11/25 at 9:42 A.M. with CNA #183 revealed that Resident #40 rarely ever participates in activities. Interview on 12/11/25 at 1:20 P.M. with the Assistant Director of Nursing (ADON) #168 confirmed Resident #40's care plan dated 10/07/25 did not have specific interventions for her interest and that the annual/comprehensive MDS section for patient preferences and activities was not completed on 01/28/25. Review of the facility policy titled Activities, dated 10/2022 revealed each resident's interest and needs will be assessed on a routine basis, including residents' interest, preferences, and needed adaptations. The policy further indicated special considerations will be made for developing meaningful activities for residents with dementia and/or special needs, including but not limited too, Residents who have withdrawn from previous activity interest/customary routines, and isolates self in room/bed most of day. This deficiency represents non-compliance investigated under Complaint Number 2669867.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record, policy review, staff and resident interviews, the facility failed to provide routine dental services to one (Resident #53) of two residents reviewed for dental services. The facility census was 51. Findings Include: Record review revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including kidney disease, enlarged prostate, lung disease, anemia, high blood pressure, reflux, Alzheimer's Disease, dementia, anxiety and depression. Record review of Resident #53 most recent Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed a Brief Interview of Mental Status score of 15/15 meaning the resident was cognitively intact with no impairments. The MDS further noted Resident #53 use of wheelchair for mobility and supervision or minimal assistance with transfers and personal care. The MDS also noted no swallowing disorders and that Resident #53 was following a mechanical soft diet. Record review of dental progress notes dated 01/20/25 written by Dentist #310 revealed Resident #53 had a full mouth teeth extraction completed. Further review revealed a follow up dental evaluation completed on 08/01/25 with Dentist #310 noting that Resident #53 has no maxillary or mandibular bone to fabricate dentures on and would need to look into dental implants or implant support dentures. This information was relayed by the dentist to both the Social Worker Designee (SWD) #158 and Resident #53 at the time of the appointment. Interview on 12/08/25 at 10:12 A.M. with Resident #53 revealed he reported having trouble getting new false teeth. Resident #53 further reported that he had notified the Activities Director (AD) #101 several weeks ago and was told that his sister has to make his appointment and arrangements and check with his insurance and doesn't understand why the facility can't do it. Resident #53 further reported that he has been getting a mechanical soft diet and is tired of it and wants regular foods. Interview on 12/09/25 at 2:03 P.M with Resident #53 during resident council meeting revealed concerns with not getting his dentures. Resident #53 reported that he was last to the dentist about six months ago and was told he would have to live without them. Interview on 12/09/25 at 2:15 P.M. with AD #101 during resident council revealed she had talked to Resident #53's sister and told her she needed to make an appointment because she was the power of attorney and that the facility could not make the appointment. AD #101 further reported Resident #53 sister was working on getting him an appointment. Interview on 12/10/2025 at 10:19 A.M. with SWD #158 revealed she had not received any reports or concerns from Resident #53 or staff about him wanting new dentures. SWD #158 further confirmed that during the dental evaluation on 08/01/25 it was relayed to both her and Resident #53 that he would not be able to wear dentures and the Resident just said okay. SWD #158 reported that the Assistant Director of Nursing (ADON) #168 makes outside facility appointments for all residents and she coordinates with contracted ancillary service company 360 for dental, vision, hearing, and podiatry appointments. Interview on 12/10/2025 at 10:59 A.M. with the AD #101 revealed approximately six weeks ago Resident #53 reported he had seen some commercials that there was a place that could do dentures for anyone and he wanted to go there because the dentist from facility said he couldn't get them. AD #101 reported she told Resident #53 to call his sister who is the power of attorney and have her schedule an appointment. The AD #101 then reported that Resident #53 had his sister call the AD #101 and his sister said she would have to look into his Medicaid to see if he was allowed to have another dental visit or if Affordable Dentures was covered by Medicaid. AD #101 further reported she had not talked with Resident #53 sister since. AD #101 reported she had not notified nursing or social services about the Resident #53 concerns. AD #101 further reported she did tell the SWD #158 yesterday after Resident Council meeting about Resident #53 concerns about [NAME] wanting dentures. Review of facility policy titled Dental Services dated 10/22/24 revealed the facility is to assist residents in obtaining routine and emergency dental care including if requested making dental appointments and arranging transportation. Further review of the policy revealed routine dental services to include taking impressions for dentures and fitting dentures and limited prosthodontic procedures.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Resident #26's medication orders and administration record were accurate. This affected one (Resident #26) of six residents reviewed for medication administration. The facility census was 51. Findings include: Review of medical record for resident #26 revealed an admission date of 06/25/21. The resident had diagnoses that included Parkinson's Disease; anxiety disorder, unspecified; unspecified dementia, severe, with agitation; unspecified protein-calorie malnutrition; benign prostatic hyperplasia without lower urinary tract symptoms; essential hypertension; Parkinsonism; schizophrenia; unspecified mood; tremor; other bipolar disorder; specified peripheral vascular diseases; abnormal involuntary movements; vitamin D deficiency; constipation; restlessness; cramp and spasm; encounter for palliative care; anemia; depression; pain in knee; edema; unspecified urinary incontinence; full incontinence of feces; and Alzheimer's disease with early onset. Review of the Minimum Data Set (MDS) version 3.0, dated 10/28/25, revealed a Brief Interview for Mental Status (BIMS) could not be completed due to the resident was rarely/never understood. Further review of the MDS, Section E, indicated Resident #26 had no hallucinations or delusions. Section GG, functional abilities, indicated the resident was wheelchair bound, dependent for all activities of daily living. Review of the orders for Resident #26 revealed a Xanax order dated 08/07/24. The order was for Xanax 0.5 milligrams (mg), give one tablet by mouth three times daily for anxiety and written by Nurse Practitioner (NP) #304. The order remained active on 12/09/25. This was confirmed by RN #174 on 12/09/25 at 1:58 P.M., at the time the order was reviewed. Review of a document titled controlled drug/receipt/record/disposition form for Resident #26, dated 11/17/25, revealed a prescription sticker for Alprazolam 0.5mg by mouth three times a day as needed for anxiety and agitation. This prescription was ordered 11/16/25 by Hospice Physician #301 with delivery to the facility on [DATE]. The medical record failed to reveal a prescription confirming this prescription. Review of a prescription obtained from Remedi pharmacy revealed a prescription for Xanax 0.5mg one tablet by mouth three times daily as needed for anxiety. Review of the medication administration record for Resident #26 revealed from 11/17/25 through 12/09/25, the resident was receiving Xanax 0.5mg three times daily, despite an medication orders from Remedi pharmacy which indicated Xanax 0.5mg by mouth three times daily as needed. Interview with Certified Pharmacy Technician (CPT) #200 on 12/09/25 at 4:23 P.M. confirmed the as needed Xanax prescription was ordered. An interview on 12/09/25 at 4:25 P.M. with Director of Nursing confirmed the facility nurses were giving Xanax 0.5mg three times daily (scheduled), not as needed per most recent order. On 12/10/25 at 3:03 P.M., an interview with Registered Nurse (RN) #306 revealed the Xanax order should never have changed from scheduled three times daily to three times daily as needed. She explained an on-call nurse for hospice took the call from the facility on 11/15/25, indicating Resident #26 required a refill for his Xanax. The on-call nurse erroneously entered the prescription as an As needed or PRN medication, rather than a scheduled three times daily medication, which was the existing order. This order was then sent to the hospice physician for approval and submission to the pharmacy. RN #306 revealed the orders in the hospice medical record still indicated Resident #26's order for Xanax was 0.5mg one tablet by mouth three times daily for anxiety, and was never intentionally changed to as needed. Review of a facility policy titled Medication Administration, dated 08/25/25, revealed medications were to be administered by licensed nurses, as ordered by the physician, and in accordance with professional standards. Nurses were to ensure the six rights of medication were followed, which included the right dosage. Nurses should compare the medication source (bubble pack, vial, etc.) with the medication administration record (MAR) to verify resident name, medication name, form, dose, route and time.		