STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365551	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovernook Health Care and Rehabilitation Center	7025 Clovernook Avenue Cincinnati, OH 45231

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51680 Based on observation, staff interview and medical record review and review of facility policy, the facility failed to ensure dignity was maintained during mobility assistance for Resident #54. This affected one resident (#54) of four residents reviewed for dignity. The facility census was 111. Findings include: Review of Resident #54's medical record revealed an admitted [DATE]. Diagnoses included Huntington's disease. Review of the annual Minimum Data Set (MDS) assessment, dated 04/09/24, revealed Resident #54 had a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident had severe cognitive impairment. The MDS indicated the resident used a manual wheelchair and required substantial/maximal assistance from staff to wheel 50 to 150 feet. Review of the care plan, revised 08/01/24, revealed Resident #54 was at risk for falls. Interventions included may get up in a reclining geri (geriatric) chair. Observation on 10/22/24 at 10:50 A.M. revealed Certified Nursing Assistant (CNA) #1 walked out of Resident #54's room, pulling a mobile reclining geriatric chair backwards with Resident #54 seated in the chair. CNA #1 pulled the mobile reclining geriatric chair from the resident's doorway to the nurse's station, located approximately twenty-five feet away from the resident's room. Interview on 10/22/24 at 10:59 A.M. with CNA #1 confirmed she pulled Resident #54 backwards in her geri chair. CNA #1 stated stated pulling the resident's geri chair was easier, but they should probably push, not pull, the chair. Interview on 10/22/24 at 12:11 P.M. with Licensed Practical Nurse/Unit Manager (LPN/UM) #4 revealed it was not appropriate to pull geri chairs backwards. Interview on 10/23/24 at 9:54 A.M. with CNA # 2 revealed staff should never pull chairs to transport residents; rather, they should push chairs with the resident facing forward so the residents can see. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/23/24 at 3:00 P.M. with the Director of Nursing (DON) revealed the expectation was for staff to push chairs forward. The DON stated there was never a time staff should pull a resident backwards in their chair. The DON stated staff had been educated on dignity and properly transporting residents in chairs. Review of facility policy titled Dignity, revised February 2021, revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 42374 Based on review of resident fund authorizations and staff interview, the facility failed to ensure resident authorization to establish a Resident Funds Trust Account was witnessed by someone who was not an employee of the facility. This affected two residents (#9 and #73) of six residents reviewed for resident funds. The facility census was 111. Findings include: 1. Review of the resident funds management authorization and agreement, undated, revealed Resident #9 and Business Office Manager (BOM) #25 signed the document. Further review revealed the written authorization revealed no witness signature. 2. Review of the resident funds management authorization and agreement, dated 10/25/23, revealed Resident #73 signed the authorization. The document was also signed by BOM #25. Further review revealed the written authorization revealed no witness signature. Interview on 10/23/24 at 2:33 P.M. with BOM #25 confirmed the authorization forms were not witnessed by someone who was not an employee of the facility.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 42374 Based on review of resident fund documents and staff interview, the facility failed to notify residents when available funds were within the $200.00 Medicaid resource limit. This affected one resident (#7) of six residents reviewed for personal funds. The facility census was 111. Findings include: Review of Resident #7's quarterly resident account statements revealed on 04/01/24 the resident's balance was $1,974.44. Further review revealed no evidence Resident #7 was notified he was within $200.00 of the $2,000.00 Medicaid resource limit. Concurrent interview with Business Office Manager (BOM) #25 verified the finding and stated she thought the resource limit was $2500.00, not $2000.00.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36105 Based on observation, medical record review, staff interview, pharmacist interview and review of facility policy, the facility failed to ensure resident's were free from significant medication errors during insulin administration. This affected one resident (#1) of six residents reviewed for medication administration. The facility census was 111. Findings included: Review of Resident #1's medical record revealed an admitted [DATE] and a readmitted [DATE]. Diagnoses included type two diabetes mellitus. Review of Resident #1's current physician orders revealed an order for Novolog (rapid-acting) insulin to be administered subcutaneously according to a sliding scale three times a day. Additionally, Resident #1 had an order for Lantus (long-acting) insulin, six units to be administered subcutaneously at bedtime. Review of the Medication Administration Record (MAR) for October 2024 revealed Resident #1's sliding scale Novolog was scheduled to be given each day at 8:30 A.M., 12:30 P.M. and 4:30 P.M., and the resident's Lantus was scheduled to be administered each day at 8:30 P.M. Further review of the MAR revealed on 10/23/2024, Resident #1's glucose reading was recorded as 262 milligrams (mg) per deciliter, which required 6 units of Novolog per the sliding scale orders. Observation on 10/23/24 at 7:52 A.M. of medication administration with Registered Nurse (RN) #5 revealed RN #5 administered six units of Lantus to Resident #1, instead of the sliding scale Novolog that was scheduled for 8:30 A.M. Interview on 10/23/24 at 10:24 A.M. with RN #5 and Licensed Practical Nurse (LPN) #6 revealed RN #5 was a recent hire and currently in training. LPN #6 stated she prepared Resident #1's medication and RN #5 administered the medication. RN #5 confirmed Resident #1 had both a Novolog and a Lantus insulin pen in the medication cart. RN #5 further stated she only administered one of the resident's insulins and agreed she had administered the Lantus, instead of the Novolog. LPN #6 stated that Resident #1 should receive Novolog three times per day and Lantus at night. However, LPN #6 stated that, despite having given the medication to RN #5 to administer to the resident, she thought Resident #1 was given the Novolog since the resident was not supposed to get Lantus until nighttime. LPN #6 acknowledged that giving the resident Lantus instead of their sliding scale Novolog was a medication error and said she would inform the Assistant Director of Nursing (ADON) of the error immediately. Interview on 10/23/24 at 10:43 A.M. with ADON #8 revealed Resident #1 received the wrong insulin this morning and would need to be monitored for potential adverse effects. Interview on 10/25/24 at 10:50 A.M. with Pharmacist #10 revealed when the nurse administered Resident #1's Lantus insulin instead of their Novolog insulin, it was an error because Novolog and Lantus were different types of insulins, and the Lantus that was administered in error was considered a long-acting insulin. Pharmacist #10 stated the resident required monitoring throughout the remainder of the day to ensure there was no adverse effects due to the error. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Administering Medications, revised April 2019, revealed medications are administered in a safe and timely manner, and as prescribed. Additionally, 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 and 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. Review of the facility policy titled Insulin Administration, revised September 2014, revealed the type of insulin, dosage requirements, strength and method of administration must be verified before administration to assure that it corresponds with the order on the medication sheet and the physician's order. Per the policy, the types of insulin included rapid-acting and long-acting. The policy specified rapid-acting insulins had an onset timeframe of 10 to 15 minutes, peak effects were achieved within a half-hour to three hours, and the duration of effects lasted between three to six hours. The policy specified long-acting insulins had an onset timeframe of one to two hours, peak effects were achieved up to eight hours after administration, and the duration of effects lasted up to 24 hours. This deficiency represents non-compliance investigated under Master Complaint Number OH00159115.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36105 Based on medical record review, observation, staff interview, review of the Individual Control Drug Record (ICDR)and review of facility policy, the facility failed to ensure a narcotic medication was accurately labeled to reflect current physician orders. This affected one resident (#367) of six residents reviewed for medication administration. The facility census was 111. Findings include: Review of Resident #367's medical record revealed an admitted [DATE]. Diagnoses included chronic pain syndrome. Review of Resident #367's current physician orders revealed an order for oxycodone five milligrams (mg), two tablets every eight hours as needed for pain. Review of Resident #367's Medication Administration Record (MAR), for the timeframe from 10/01/24 through 10/25/24, revealed an order started on 10/05/24 and discontinued on 10/10/24 for oxycodone five mg, one tablet every four hours as needed for pain. The MAR also revealed an order started on 10/10/24 for oxycodone 5 mg, two tablets every eight hours as needed. Review of the ICDR for oxycodone five mg tablets revealed a label that indicated the pharmacy dispensed 60 oxycodone 5 mg tablets on 10/05/24. The label instructions specified to take one tablet by mouth every four hours as needed for pain. The ICDR further revealed that from 10/05/24 through 10/10/24, staff documented the amount given as one tablet and from 10/11/24 through 10/22/24, staff documented the amount given as two tablets. There was no documentation on the ICDR to reflect the physician's order was changed on 10/10/24 to oxycodone five mg tablets, two tablets every eight hours as needed. Interview on 10/22/24 at 4:51 P.M. with Licensed Practical Nurse/Unit Manager (LPN/UM) #4 revealed the label affixed to Resident #367's multidose medication blister pack card of oxycodone five mg tablets specified to take one tablet by mouth every four hours as needed for pain. LPN/UM #4 stated Resident #367's order changed to two tablets every eight hours on 10/10/24. LPN/UM #4 stated there was not a process to match the MAR with the actual medication label or to change the medication label when an order changed. LPN/UM #4 stated the medication label would be changed on the next multidose medication blister pack delivery from the pharmacy, but not on the original blister pack or controlled drug sheet. Interview on 10/24/24 at 10:54 A.M. with the Director of Nursing (DON) revealed the system was if a resident had a blister pack of medication with a changed order, the nurse should indicate there was a change of order in red ink or place a change of order sticker on the label. The DON stated leaving the old label on a narcotic without a changed order statement could be risky because it could be confusing to an agency nurse to determine what should be given to Resident #367 if the medication card did not match the order. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/25/24 at 10:50 A.M. with Pharmacist #10 revealed nurses should not give medication if the label was wrong. Pharmacist #10 stated the label must match the order, including the medication, dose, and any other instructions. She stated if an order changed, then the blister pack card and the controlled medication sheet should be updated by noting an order change was completed. Review of the facility policy titled Labeling of Medication Containers, dated April 2019, revealed any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy. Additionally, labels for individual resident medications include all necessary information, such as: the resident's name; prescribing physician's name; the name, address,and telephone number of the issuing pharmacy; the name, strength, quantity of the drug; the prescription number, (if applicable); the date the medication was dispensed; appropriate accessory and cautionary statements; the expiration date when applicable; and directions for use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42192 Based on observation, staff interview and review of facility policy, the facility failed to ensure dented cans were not in circulation for use. Additionally, the facility failed to ensure residents' food items stored in unit refrigerators were labeled and dated and further failed to ensure unit refrigerators were clean and consistently monitored to ensure appropriate food storage temperatures. This had the potential to affect all residents except three (#77, #94 and #100) identified by the facility as receiving no food by mouth. The facility census was 111. Findings include: 1. Observation on 10/21/24 at 10:39 A.M. of the kitchen revealed the canned food rack contained four dented cans, including two six-pound cans of pineapple with dents on the top and bottom of the cans, one six-pound can of mandarin oranges with a dent below the top seal, and a six-pound can of stew vegetables with a dent in the top seal. Concurrent interview with Dietary Manager (DM) #24 verified the findings. DM #24 revealed when she unloaded orders of canned goods, she checked the tops and outside of the cans for leaks or bulging spots. She stated if there was a dent on the seal, the food inside the can could be compromised. She stated dented cans should be removed and returned for credit. DM #24 stated she thought one of the cooks may have put the order away. Interview on 10/24/24 at 12:55 P.M. with [NAME] Supervisor (CS) #29 revealed she sometimes helped put orders away. CS #29 stated that when putting away cans, staff should check for dents and discoloration around the rim. She stated if a can was dented, DM #24 was informed and the dented can was put in DM #24's office. CS #29 stated risks from dented canned foods included bacterial growth, such as listeria, and could introduce foodborne illness to the facility. Interview on 10/25/24 at 9:58 A.M. with the Director of Nursing (DON) revealed dented cans could have air inside, which did not seem safe. She stated she expected any cans found dented while unpacking an order to be returned. Review of the facility policy titled Food Receiving and Storage, revised October 2017, revealed when food is delivered to the facility, it will be inspected for safe transport and quality before being accepted. 2. Interview on 10/24/24 at 12:50 P.M. with DM #24 revealed dietary staff were to check the temperatures of the unit refrigerators daily. Observation on 10/24/24 at 1:38 P.M. of the first floor unit refrigerator revealed no evidence temperatures were monitored. Further observation revealed the following: An unlabeled foam container with a barbecue chicken tender underneath a napkin. A to-go cup from a local restaurant, dated 10/15/24. The to-go cup was covered with a plastic lid with a straw inserted and was not labeled with a name. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A dirty, empty food-storage container with no name or date. An open box of pizza snack rolls with no name or date. The box indicated to keep frozen , but the pizza snack rolls were thawed. A bag of fast-food from a local barbecue restaurant not labeled with no name or a date. An 18-count box of eggs with nine remaining eggs, dated March 03 (no year). An open bag of shredded cheddar cheese dated 07/14/24. A plastic shopping bag was stuck to the bottom of the refrigerator and contained a bottle of ranch dressing with an expiration date of January 2025, an undated bag of croutons, an undated package of pecan pinwheels and an undated container of unknown leftovers. Interview on 10/24/24 at 2:38 P.M. with DM #24 verified the above findings. DM #24 stated the items should have been thrown away and should not have been in the unit refrigerator. She stated all items should be labeled and dated. She further stated the eggs should not have been in the refrigerator, because the facility did not use whole raw eggs. DM #24 also stated if food items indicated they should be kept frozen, they should be kept in the freezer. DM #24 stated dietary staff were responsible for cleaning and monitoring the unit refrigerators, but they did not know when the food items were brought into the facility or by whom. DM #24 stated she was not aware of a facility procedure for ensuring residents' food items were labeled and dated. 3. Observation on 10/24/24 at 2:00 P.M. of the third floor unit refrigerator revealed the thermometer inside displayed 30 degrees Fahrenheit (F), but no temperature tracking log was observed. Further observation revealed a bag of leftovers from a fast-food restaurant was not labeled or dated and a bag of unknown leftovers, dated 10/04/24, with an illegible name written on the container, were observed in the refrigerator. A red stain was observed on the floor of the refrigerator and the bottom shelf of the door. Continued observation of the freezer compartment revealed there was no thermometer to monitor the temperature and and a frozen yellow fluid was on three-quarters of the bottom surface of the freezer. Interview on 10/24/24 at 2:16 P.M. with DM #24 verified the above findings and further stated leftovers should be labeled with a name and a date and should be discarded after seven days. Interview on 10/24/24 at 2:12 P.M. with CS #29 revealed dietary staff were responsible for the unit refrigerators. She stated DM #24 checked the unit refrigerators and let dietary staff know if they needed to be cleaned. CS #29 said residents' food items should be labeled with their name and a date and leftover food items in unit refrigerators should be thrown out after three days and discarded if they were not labeled with a name or a date. According to CS #29, unit refrigerators were cleaned once per week and temperatures should be logged at that time. Interview on 10/24/24 at 3:15 P.M. with Medication Technician (MT) #21 revealed nursing staff who received residents' food items should label the items with the resident's name and a date before placing the items into the refrigerator. MT #21 stated she assumed dietary staff were responsible for cleaning and monitoring the unit refrigerators because no one had told nursing staff anything about doing it. She stated residents' leftover food items should not be kept for more than a few days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/24/24 at 4:07 P.M. with LPN/Unit Manager (LPN/UM) #15 revealed dietary staff were responsible for checking dates on food items and for cleaning and monitoring the unit refrigerators. LPN/UM #15 further stated food items should be labeled with the resident's name and a date by either the resident, their family or the staff member receiving the food items. Interview on 10/25/24 at 6:09 A.M. with LPN/UM #20 revealed residents' food items should be labeled by the resident or the staff member who received the items. LPN/UM #20 said nursing staff monitored the unit refrigerators to ensure food items were discarded after 24 hours. LPN/UM #20 further stated nursing staff should also monitor the temperature of the unit refrigerators and document once per shift; however, she did not know where the temperature tracking logs for the unit refrigerators were located. Observation on 10/25/24 at 6:15 A.M. of the first-floor refrigerator with LPN/UM #20 revealed the unlabeled bag of fast-food leftovers and the thawed box of pizza snack rolls observed on 10/24/24 remained in the refrigerator. LPN/UM #20 stated the food items in the refrigerator should be labeled and dated with the resident's name and the date the food was brought into the facility. She stated the items observed in the refrigerator should not have been there and said any nursing staff could remove items that were undated and unlabeled or past their use by date. Interview on 10/25/24 at 9:58 A.M. with the DON revealed she expected dietary staff to check the unit refrigerators weekly for old, undated or unlabeled items, as well as for cleanliness. She stated she would hate for a resident to have food in the refrigerator for too long, eat it and get sick. The DON stated nursing staff should be labeling and dating food items brought into the facility, and no food items should be unlabeled or undated. She stated items that were undated should be thrown away because there was no way to know how long the item had been in the refrigerator. The DON stated she thought the unit refrigerators' temperatures needed to be documented daily but was unsure how dietary tracked it. Interview on 10/25/24 at 11:19 A.M. with the Administrator revealed unit refrigerators should be cleaned on a schedule and food brought in from outside should be labeled and dated by staff and placed in the refrigerator. The Administrator stated residents could also label and date their food items, but some residents forgot before putting the items in the unit refrigerator. The Administrator stated she was unsure how unit refrigerator temperatures should be tracked. Review of the facility policy titled Refrigerators and Freezers, revised December 2014, revealed the facility will ensure safe refrigerator and freezer maintenance, temperatures and sanitation, and will observe food expiration guidelines. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures and the tracking sheets will include time, temperature, initials and action taken. Food Service Supervisor or designated employees will check and record refrigerator temperatures daily with the first opening and at closing in the evening. Review of the facility policy titled Food Receiving and Storage, revised October 2017, revealed food items and snacks kept on the nursing units must be maintained as follows: all food items must be placed in the refrigerator located at the nurses' station and labeled with a use by date; all food belonging to residents must be labeled with the resident's name, the item and the use by date; refrigerators must have working thermometers and be monitored for temperature; beverages must be dated when opened and discarded after twenty-four (24) hours; other open containers must be dated and sealed or covered during storage; and partially eaten food may not be kept in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated facility policy titled Foods Brought by Family/Visitors, revealed food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. Non-perishable foods will be stored in re-sealable containers with tight-fitting lids. Intact fresh fruit may be stored without a lid. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date. Lastly, nursing staff will discard perishable foods on or before the use by date.

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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 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** 36105 Based on medical record review, staff interview and review of facility policy, the facility failed to ensure resident medical records contained complete and accurate information. This affected one resident (#367) of six residents reviewed for medication administration. The facility census was 111. Findings include: Review of Resident #367's medical record revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus. Review of the Medication Administration Record (MAR) for October 2024 revealed the transcription of an order, started on 10/09/24 and discontinued on 10/21/24, for Trulicity subcutaneous solution pen injector 1.5 milligrams (mg) per 0.5 milliliters (mL) to be administered subcutaneously weekly on Wednesdays. According to the MAR, on 10/21/24, the resident's Trulicity order was changed to Trulicity subcutaneous solution pen injector 1.5 mg per 0.5 mL to be administered subcutaneously weekly on Mondays. The MAR reflected the resident's Trulicity was scheduled to be given on 10/09/24, 10/16/24 and 10/21/24. The MAR revealed documentation that indicated the resident's 10/21/24 Trulicity dose was administered; however, the scheduled doses on 10/09/24 and 10/16/24 were documented as a 9, which indicated Other/See Progress Notes. Resident #367's Progress Notes revealed the following EMAR [electronic medication administration record]-Administration Notes: - a note dated 10/09/24 at 6:30 P.M. that reflected the resident's Trulicity order; however, the note did not indicate if the medication was administered or any details describing what transpired at the scheduled time of administration - a note dated 10/16/24 at 10:34 A.M. that reflected the resident's Trulicity order and an entry indicating the pharmacy was notified; however, the note did not indicate if the medication was administered, did not include any details describing what transpired at the scheduled time of administration and did not include any information regarding what the pharmacy was notified of. Interview on 10/22/24 at 2:20 P.M. with Licensed Practical Nurse (LPN) #11 confirmed she documented the 9 on Resident #367's MAR for the Trulicity on 10/09/24. LPN #11 did not recall any details regarding what transpired or whether she contacted the pharmacy or physician. LPN #11 said she should have document details in the resident's progress notes. Interview on 10/22/24 at 3:05 P.M. LPN/Unit Manager (LPN/UM) #4 stated the expectation was that if a nurse documented 9 on a resident's MAR, the nurse should document details in the resident's record to explain what happened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365551	A. Building B. Wing	10/25/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Administering Medications, revised in April 2019, revealed if a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall complete appropriate documentation on the MAR for that drug and dose. Additionally, the individual administering the medication records in the resident's medical record: the date and time the medication was administered; the dosage; the route of administration; the injection site (if applicable); any complaints or symptoms for which the drug was administered; any results achieved and when those results were observed; and the signature and title of the person administering the drug.