STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525542	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Care Center	1400 8th Ave Union Grove, WI 53182

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37283 Based on interview, record review, and review of facility policy, the facility failed to thoroughly investigate the death that occurred for 1 of 3 sampled residents R4 reviewed for abuse and/or neglect of eight sample residents. R4 died of a presumed suicide. The facility did not thoroughly investigate the death Findings include: Review of the facility's policy titled, Investigation and Reporting of Alleged Incidents of Abuse, Neglect, and Misappropriation, dated ,d+[DATE], stated All abuse, neglect, and exploitation of residents and misappropriation of resident property are prohibited at [Name of facility]. All alleged violations will be taken seriously and investigated and reported as necessary .1. All alleged violations involving mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property shall immediately be reported to the Administrator (or designee), the employee's supervisor, or nurse who will immediately report to the Administrator (or designee) .e. Examples of neglect include, but are not limited to: ignoring a resident's need for help, not providing food or water, or withholding care . Review of R4's Face Sheet, dated [DATE] and provided by the facility, indicated R4 was admitted to the facility on [DATE], with diagnoses which included other fracture of upper and low-end fibula, subs for closed fracture with routine heal. Thorough review of facility documentation and R4's medical record indicated nothing to show that a thorough investigation had been conducted related to the resident's death, to include all staff and resident interviews about possible causes of the death. Review of R4's Reportable Death Determination, dated [DATE] and provided by the facility, indicated Nurse last saw resident at 10:45 PM on [DATE] sleeping in his bed with his oxygen on. The nurse stated that he could see the resident's chest rise and fall, ensuring that he was breathing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:25 PM on [DATE], CNA D (Certified Nurse Aide) completed last rounding and checked on resident. CNA saw a plastic bag over the resident's head. CNA ran to get nurses, and nurses responded immediately. Resident had the plastic bag over his head and his oxygen tubing tightly wrapped around his neck. The nurses tore the bag off of the resident's head and unwrapped the tubing, but resident was nonresponsive and not breathing. He was pale with no pulse. Resident is a DNR [Do Not Resuscitate] and had a bracelet on; CPR [cardiopulmonary resuscitation] was not given. DON B (Director of Nursing, ANHA F (Assistant Nursing HOme Administrator) NHA A (Nursing Home Administrator) were notified. Police were called; case number provided. The Medical Examiner was called in. Medical Examiner stated that the cause of death of probable suicide. The Administrator called family contact to update on incident. During an interview on [DATE] at 2:15 PM, ANHA F confirmed that the information that she provided was all that had been done related to R4's death investigation. She stated she arrived at the facility on [DATE] at 2:00 AM, and took statements from CNA D, Licensed Practical LPN N (Licened Practical Nurse and LPN M. She stated that residents were observed to ensure their safety, but no statements were taken from the residents. She stated that the Sheriff gathered statements from the three staff members that were with R4.

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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 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37283 Based on interviews, record review, and facility policy review, the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of 1 of 8 sampled residents. On [DATE], R4 reported being depressed and having thoughts that he would be better off dead or of hurting himself almost daily. The facility did not provide R4 with support or services to address these concerns. Approximately 8 hours later, R4 was found pulseless and non-breathing with a plastic bag over his head and the oxygen tubing wrapped around his neck. The facility's failure to provide support and monitoring to R4 after making statements that he was depressed and had thoughts that he would be better off dead nearly every day created a finding of immediate jeopardy that began on [DATE]. NHA A (Nursing Home Administrator) was notified of the finding on [DATE] at 2:07 PM. Findings include: Review of the facility's policy titled, Facility Investigations of Resident Threats to Harm Self dated ,d+[DATE], stated .1. Should resident voice intent or attempt to harm themselves in any way staff will immediately intervene in order to stop negative behavior and to assure safety .2. Based on the severity of the occurrence immediate nursing interventions to consider would be .a. assure no bodily harm has occurred (i.e. redness, bruising, swelling, etc.) through a body check .b. initiate 1:1 care .c. initiate 15 minute checks .d. consider sending resident out to the hospital if dangerous behavior continues .e. remove items from room that which resident could potential harm themselves with .f. inform dietary should resident need plastic utensils .3. Nurse must notify the following people of the incident: .a. the on call Nurse Manager; the on call Nurse Manager is then responsible for notifying the Administrator or designee .b. the resident's primary physician . c. the resident's family . d. third parties such as Hospice or Partnership .e. the resident's facility Social Worker .4. The resident's Social Worker or designee is responsible for completing a thorough and immediate investigation of the situation by: a. interviewing the resident .b. interviewing any potential witnesses (i.e. other residents if cognitive, staff, visitors) .5. Social Services must attempt to determine reasons for the threat. Reasons to consider may include: a. diagnosis (i.e. Depression, Anxiety, Bipolar disease, etc.) .b. adjustment or grieving issues . c. attention seeking behavior . d. lack of family/friends . e. medication changes . f. overall decline in health; loss of independence . 6. Upon determining potential reasons for the threat Social Services or the designee must then update the resident's plan of care. Resident's care plan goal and interventions must include a review date and end date. Based on the reason for the threat possible. Social Service interventions to consider may include: a. increase of 1:1 visits with resident by Social Services .b. consider recommending consult with in-house psychologist if not already seeing .c. if already seeing in-house psychologist, contact to inform of situation . d. consider recommending consult with outside psychiatrist . 7. Social Services and Nursing to work together to communicate any new interventions to staff via: a. verbally communicating with C.N.A.'s on resident's hall . b. written documentation on 24 hr. board . 8. Social Services must document their investigation and submit to the Administrator for review. (continued on next page)

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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 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4 was admitted to the facility on [DATE] with diagnoses which included other fracture of upper and low-end fibula, subs for closed fracture with routine heal. Review of the undated diagnosis list provided by the facility revealed no diagnosis of depression, anxiety, or other mental health issues. Review of R4's Care Plan, dated [DATE] at 7:47 PM indicated R4 had the potential to feel anxious, scared, angry, sad, alone, or isolated. The care plan indicated that R4 needed nurses to ask me how I am feeling, identify my patterns of behavior, provide me with clear explanations, assess my medication. I need social services to establish a quiet environment for me, provide me with regular counseling. Review of R4 physician orders, dated [DATE] and provided by the facility, revealed medication orders for risperidone (anti-psychotic medication) 0.5 MG (milligram) tablet by mouth every 12 hours for tremors. Review of nurse's note dated [DATE] at 1:34 PM and provided by the facility, revealed R4 had a diagnosis of dementia, was his own decision maker, alert and oriented with confusion. Review of R4's Patient Health Questionnaire (PHQ), provided by the facility, was completed by AA C (Admission Assistant) on [DATE], at 2:56 PM. The PHQ revealed that R4 answered yes to thoughts that he would be better off dead, or hurting himself in some way, nearly every day. When asked if he was depressed, R4 answered yes. During an interview on [DATE], at 6:25 PM, AA C (Admissions Assistant) stated she told APSW (Advanced Practice Social Worker) right away that R4 answered yes to being depressed, having thoughts that he would be better off dead, or of hurting himself in some way. AA C stated R4 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he was cognitively intact. During an interview on [DATE], at 6:45 PM, APSW E stated that AA C told her on [DATE] that R4 had answered yes to the question that he would be better off dead. APSW E stated, Since it was the end of the day, I figured I would just take care of it the next day. When asked if she documented this conversation, APSW E stated that she typically does not document conversations between coworkers; only when the resident tells her directly. APSW E stated she was not made aware the resident answered yes to being depressed. She stated if she was aware that there were additional yes answers on the PHQ, she would have done something about the resident at the time. When asked why she did not take action after the admissions assistant informed her of the assessment, APSW E responded, It was the end of the day. Review of nurse's note dated [DATE] at 3:37 PM and provided by the facility, noted R4's mood: Did not indicate concern with R4 making any negative statements or verbalized self-worthlessness in the past month. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 6:13 PM, CNA D (Certified Nursing Assistant) stated that he was doing his final check on [DATE] at 11:25 PM and he was going up and down the hallways. He stated that he went into R4's room, and it was dark, so he turned on his light to check on him. He stated that observed R4 had a clear plastic trash bag over his head. He stated that he could tell that R4 was not breathing, so he ran quickly to get a nurse. CNA D stated that they ran back down to R4's room, the nurse removed the bag from over his head and checked his vitals. He stated R4 had a Do Not Resuscitate (DNR) bracelet on his wrist, and cardiopulmonary resuscitation (CPR) was not initiated. He stated that he wrote a statement for the facility and a statement with the police. CNA D stated, The oxygen tubing was wrapped around the bag that was over R4's head and R4 did not have the oxygen tubing in his nose. During an interview on [DATE] at 1:55 PM, the AA C stated that she had a discussion with NHA A, ANHA F (Assistant Nursing Home Administrator), APSW E, and AC G (Admission Coordinator) on [DATE]. She stated that she did not recall the time that the meeting was held. She stated that the group discussed and decided to archive the PHQ because R4's statements were taken out of context. When asked what it meant that the statement was taken out of context AA C indicated they said it was because he was cheerful, he was [AGE] years old, has lived his life, and if it happens it happens. During an interview on [DATE] at 2:25 PM, the ANHA F that on [DATE], the team met to discuss the incident and the assessment that was conducted. She stated that based off the way the resident had responded to the questions, they were taken out of context. She stated that R4 did not directly state he would hurt himself. Review of Facility Reportable Death Determination-F62470, dated [DATE], revealed R4's cause of death was probable suicide by asphyxiation per Medical Examiner. According to the documented assessment on the PHQ, R4 indicated he was depressed and nearly every day had thoughts of being better off dead or of hurting himself. This is not the same as thinking about death daily and accepting it when it comes, as facility staff have since interpreted the resident's demeanor. Failure to recognize the resident's responses as a cry for help, to further assess the responses, and to immediately implement medically-related social services to address these concerns created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy.

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20243 Based on record reviews, interviews, and facility policy review, the facility failed to ensure that 1 of 3 sampled residents reviewed for Coumadin usage (R2) received ongoing laboratory testing to monitor the therapeutic dose the resident received. R2 was admitted to the facility with an order for Coumadin (an anticoagulation medication). Use of this medication requires frequent laboratory testing to ensure a person is receiving the correct dose to remain in therapeutic range. The last test that was completed was on [DATE]. R2 began to develop multiple bruises, which can be a sign of over anticoagulation (too much Coumadin). Neither nursing nor pharmacy identified there were no orders for labs and that R2 was not being monitored. On [DATE], R2 developed hematuria (blood in urine) and labs were ordered. Results found that R2 had critical low hemoglobin and hematocrit and critical high prothrombin and INR (International Normalization Ratio). These results are indicative of bleeding and R2 being over anticoagulated. R2 was sent emergently to the hospital where he later died . The failure to regularly monitor labs while receiving Coumadin created a finding of immediate jeopardy that began on [DATE]. NHA A (Nursing Home Administrator) was notified of the immediate jeopardy on [DATE] at 4:15 PM. The immediate jeopardy was determined to be removed and the deficiency corrected on [DATE]. Findings include: Review of facility's policy titled, Anticoagulation dated ,d+[DATE] and provided by the facility, indicated that . orders for Coumadin are received weekly by the Provider. Nursing staff will follow orders for drawing labs and giving medication as prescribed. Recommendations from the Provider will be implemented and communicated with the pharmacy also. Any abnormal lab results will be communicated with the Provider. Pharmacy completes monthly medication reviews and makes recommendations. These medication reviews are sent to the facility and reviewed by the Nurse Practitioner or Medical Director. R2 was admitted to the facility on [DATE] with diagnosis of congestive heart failure (CHF). Review of R2's diagnosis list provided by the facility revealed additional diagnoses of hypokalemia, hyperlipidemia, epilepsy, chronic obstructive pulmonary disease, unspecified intellectual disabilities, and major depressive disorder. Review of R2's Admission Weekly Skin Assessment form, dated [DATE] and provided by the facility, revealed bruising on the right posterior hand, right anterior forearm, left posterior hand, right chest, right shin, and left biceps. At the time of R2's discharge from the facility, Facility Physician Discharge Orders, dated [DATE], revealed R2 had orders for Coumadin (an anticoagulant medication) 2.5 mg (milligrams) po (by mouth) one time a week on Wednesday evening and 4 mg po daily in the evening which was started on [DATE]. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed a Physician Order, dated [DATE], for a PT/INR (Prothrombin/International Normalization Ratio), which is a test that determines how many seconds it takes a blood clot to form, to be drawn on the morning shift. Record review of Laboratory Results, dated [DATE] and provided by the facility, ordered by APNP H (Advanced Practice Nurse Practitioner), revealed no notation regarding the next PT/INR test. There was no evidence of a standing order for PT/INR and no additional labs were ordered after this date. Review of R2's Weekly Skin Assessment form, dated [DATE] and provided by the facility, revealed bruising on the right and left wrist, left bicep, left knee, and the right groin area. The MD I (Medical Doctor) was notified. Unusual or excessive bruising with no other cause identified is considered an adverse reaction with Coumadin and would indicate lab work should be completed. Review of R2's Weekly Skin Assessment form, dated [DATE] and provided by the facility, revealed that R2 had bruising inside the right cheek and bruising on the left foot. This is the second week that R2 has experienced unusual bruising. APNP H was notified. Review of R2's Nurses' Note, dated [DATE] and provided by the facility, revealed R2 was experiencing hematuria (bright red blood in the urine), yelling out, striking out at staff, refusing care, and had increased bruising with multiple etiologies. Review of a Physician Order, dated [DATE] and provided by the facility, indicated a new order for STAT (immediately) PT/INR, CBC (complete blood count), and BMP (basic metabolic panel) laboratory tests received. Review R2's Laboratory Report, dated [DATE] and provided by the facility, revealed: ~low critical hemoglobin (protein that carries oxygen through the blood) result of 6.0 g/dl (gram/per deciliter) (Hemoglobin normal range: 13XXX,d+[DATE].5), ~low critical hematocrit (the volume or percentage of red blood cells in blood) of 19% (Hematocrit normal range: ,d+[DATE]%) ~high critical prothrombin time greater than 90.0 (Prothrombin normal range: 9XXX,d+[DATE].8) ~INR (international normalized ratio) of greater than 10 (INR normal range: 2XXX,d+[DATE].5- intensive anticoagulation). Review of R2's Nurses' Note, dated [DATE] and provided by the facility, revealed the physician was notified and the physician ordered R2 be transferred to the hospital where he died on [DATE]. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:00 AM, DON B (Director of Nursing) confirmed there was no specific order for Coumadin side effect monitoring and confirmed that the January - [DATE] Medication Administration records presented by the facility did not indicate side effect monitoring for Coumadin. DON B stated she did not know why there were no orders to monitor the Coumadin with lab work. She stated as the DON, her expectation would be that the facility would ensure that residents on Coumadin were monitored with lab work and that staff would also monitor for Coumadin side effects such as bruising and bleeding. During an interview on [DATE] at 10:05 AM, the RPh J (Registered Pharmacist) stated that she was aware that R2 was on Coumadin and had seen this medication noted on his medication list. RPh J stated she had not noticed that laboratory work had not been done for the Coumadin medication. RPh J stated that she was made aware of the lack of Coumadin lab work by the facility after R2 died . RPh J stated that once she learned of the incident, there had been policy changes within the pharmacy regarding ordering and processing Coumadin medication refills because the pharmacy staff were refilling the Coumadin prescription without approval, and they were not catching that the order was old or there were no dose changes. During an interview on [DATE] at 10:18 AM, MedDir K stated that he was not aware that R2 did not have orders to monitor the Coumadin medication. MedDir K stated R2 was being followed by Nurse Practitioners at the facility. MedDir K stated that R2 had been seen by multiple clinicians and that this was a system failure. When asked what the expectation was going forward, MedDir K stated there needed to be better checks and balances for residents on Coumadin with standing orders for monitoring labs unless their Coumadin was being managed by outside clinics. MedDir K stated that he was aware that the facility had revised their anticoagulation policy after this incident. During an interview on [DATE] at 1:45 PM, APNP H stated she could not remember if she had ordered a standing lab for R2 after the [DATE] order. APNP H stated that when the results were called to the on-call physician, she may not know what the result was. During an interview on [DATE] at 3:21 PM, MD I stated that she was familiar with R2 and acknowledged that she was part of the care team. MD I confirmed she had received a report regarding R2's bruising on [DATE] but did not recall a reference to the Coumadin at the time she received the report. MD I stated that the lab work orders for Coumadin were missed by multiple people. During an interview on [DATE] at 9:30 AM, NHA A stated he did not know why the Coumadin lab work was missed. He stated that his expectation going forward was to remain on high alert for residents on Coumadin and continue to evaluate the new system for Coumadin monitoring to ensure that it was working. He stated that since the incident, there had been residents residing in the facility and the new system worked. The failure to regularly monitor residents who received Coumadin created a finding of immediate jeopardy. The facility removed the immediacy and corrected the deficiency on [DATE] by which time they had completed the following: 1. On [DATE] the facility began an investigation and identified all residents in the building who could potentially be affected and ensured that all labs and medications were up-to date and accurate. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On [DATE] the leadership team, including the NHA A, DON B, ADON L (Assistant Director of Nursing) ANHA F (Assistant Nursing Home Administrator), MedDir K, Nurse Manager, and Quality Care Coordinator conducted an Ad-Hoc (for this purpose) Quality Assurance and Performance Improvement (QAPI) meeting. The passing of the resident was reviewed. 3. The anticoagulation policy was reviewed and updated to ensure resident safety. The policy was adjusted to include standing orders for residents on Coumadin for weekly PT/INR draws upon admission to the facility. 4. During the Ad-Hoc QAPI meeting, the team also decided to add new monitoring orders upon admission, including monitoring for signs or symptoms for bleeding. 5. A Coumadin log was initiated by the nurse manager team for daily review during clinical meetings. At each clinical meeting, the clinical team reviews all residents who are prescribed Coumadin. 6. After discussing with MedDir K, the facility's pharmacy was contacted and a medication audit for all residents in the facility was completed. No other medication issues were discovered during this facility-wide medication audit. The pharmacy continues with monthly audits for all residents, and the residents on Coumadin are being monitored routinely by the pharmacy. 7. New admissions to the facility will have a prospective medication review completed by the pharmacy and the pharmacy will make note of medication that requires close monitoring. The consultant pharmacist will evaluate residents on Coumadin and clinically determine if INRs are being monitored routinely. Clinical judgement with regard to past stability of patient INR's will determine if consultant pharmacist recommends an INR for a resident for that month. 8. DON B began education on Coumadin with the nursing staff on [DATE]. All nursing staff were educated and provided with information about Coumadin. After reading and having a discussion, staff independently completed a quiz to show competency. The DON held small groups to complete this education with the nurses; additionally, the nurses were informed that if they had additional questions or concerns, they should seek out information from DON B or the ADON L accordingly. The staff were then informed about the changes being implemented regarding Coumadin. 9. The nursing staff's admission checklist and requirements include standing orders for weekly PT/INR draws for residents with Coumadin prescribed. Education began on [DATE] and all staff were educated before they began working their next shift on the floor. By [DATE], the nursing department had been educated about Coumadin and informed of the Anticoagulation policy and procedure. Upon hire, new staff members are now trained on this policy during their training period at orientation. 10. By the end of the day on [DATE], the team had contacted all parties involved to address the issue and make needed corrections. The plans put in place have thus far ensured that this mistake is prevented from occurring again. No other residents were affected, and the updated policy and procedure will keep residents safe. The facility made the necessary corrections and began monitoring immediately. 37283

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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** 20243 Based on interview and record review, the facility failed to ensure that 1 of 3 residents (R1) received accurate medication administration resulting in a significant medication error of eight sample residents. R1 received another resident's anti-seizure and laxative medications in error placing R1 at risk for discomfort and a potential risk to his health and safety. Findings include: Review of R1's undated Face Sheet provided by the facility, revealed an admitted [DATE] with an admission diagnosis of unspecified dementia. Review of R1's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/18/24, revealed R1 did not have a Brief Interview for Mental Status (BIMS) conducted and was assessed as having cognitive skills for daily decision making that was severely impaired. Review of a Medication/Treatment Error Report, dated 03/19/24 and provided by the facility, indicated that R1 received Depakote (an anti-seizure medication) 875 mg po (by mouth), Keppra (an anti-seizure medication) 500 mg po (by mouth), and lactulose 45 ml (milliliters)/30 g (grams) po (by mouth) in error given by a student nurse. The physician action was to monitor for drowsiness and aspiration in AM (morning) and PM (afternoon/evening). Review of Progress Notes, dated 03/19/24 and provided by the facility, revealed that R1 did not have an adverse reaction. During an interview on 06/25/24 at 1:00 PM, DON B (Director of Nursing) stated the student nurse was with her instructor at the time of the medication administration and that since the incident the nurse instructor was not allowed back in the facility.