

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/22/2025
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  18648 Hillcrest Rd Dallas, TX 75252	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate dispensing and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #1) of 2 residents reviewed for Pharmacy Services.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure LVN A administered medications per the Physician's Orders on 05/05/25 for Resident #1.</li> <li>LVN A filled out a wasted form when the medication was not wasted.</li> <li>MA B signed the wasted form even though she did not witness LVN A waste the medication.</li> </ol> <p>This failure could place residents at risk for worsening of their medical conditions by not receiving the therapeutic effects of medications prescribed for them, medication error, and drug diversion.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 05/23/25, revealed Resident #1 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. Resident #1's diagnoses included: transient cerebral ischemic attack (a temporary interruption of blood flow to the brain, causing symptoms similar to a stroke but with the symptoms resolving within 24 hours, usually within minutes or hours), osteoarthritis of knee (a degenerative joint disease where the protective cartilage in the knee joint breaks down, causing bones to rub together, resulting in pain, stiffness, and swelling), aftercare following joint replacement surgery, and spinal stenosis (a condition where the spaces within the spine narrow, putting pressure on the spinal cord and nerve roots), idiopathic peripheral autonomic neuropathy (nerve damage in the peripheral nervous system, specifically the autonomic nerves), and low back pain.</p> <p>Record review of Resident #1's MDS assessment, dated 05/04/25, revealed the resident had intact cognitive function with a BIMS score of 15. In Section J - Health Conditions for Pain Management, Resident #1 received a scheduled pain regimen, including PRN pain medications.</p> <p>Record review of Resident #1's Care Plan dated 05/15/25 revealed the following:</p> <p>Focus:</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>[Resident #1] had diagnosis of narcotic dependence.</p> <p>[Resident #1] will say he did not receive pain med after it has been administered, and where corrected will say he'll watch it on video .</p> <p>Date Initiated: 04/29/2025</p> <p>Revision on: 05/01/2025</p> <p>Goal:</p> <p>[Resident #1] will verbalize awareness of the relationship between substance abuse and the current situation by next review date.</p> <p>Date Initiated: 04/29/2025</p> <p>Target Date: 05/07/2025</p> <p>Interventions/Tasks:</p> <p>Educate [Resident #1] on risks of narcotic abuse.</p> <p>Date Initiated: 04/29/2025</p> <p>Pain management consult.</p> <p>Date Initiated: 04/29/2025</p> <p>Psych consult.</p> <p>Date Initiated: 04/29/2025</p> <p>Focus:</p> <p>[Resident #1] required pain management D/T osteoarthritis, joint replacement, spinal stenosis, lower back pain, and neuropathy.</p> <p>4/5/25 - Resident readmitted to facility post-surgery.</p> <p>Date Initiated: 04/30/2025</p> <p>Revision on: 05/15/2025</p> <p>Goal:</p> <p>[Resident #1] will display a decrease in behaviors of inadequate pain control example irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, groaning, crying through the review date.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's Medication Administration Record (MAR) dated May 2025 reflected:</p> <p>05/05/25 Pregabalin Oral Capsule 300 MG (Pregabalin)</p> <p>Give 1 capsule by mouth three times a day related to OTHER IDIOPATHIC PERIPHERAL AUTONOMIC NEUROPATHY .</p> <p>-Order Date-</p> <p>05/01/2025</p> <p>The MAR revealed:</p> <p>1 Capsule on 05/05/25 at 7:00 AM administered by MA B.</p> <p>1 Capsule on 05/05/25 at 1:00 PM administered by MA B.</p> <p>1 Capsule on 05/05/25 at 7:00 PM administered by LVN D.</p> <p>Record review of Resident #1's Narcotic Record for Pregabalin 100 mg CAP (generic for Lyrica) reflected the resident was ordered to receive 1 Capsule by mouth three times a day. The resident received the following doses of Pregabalin 100 mg CAP:</p> <p>1 Capsule on 05/05/25 at 7:00 AM administered by MA B.</p> <p>1 Capsule on 05/05/25 at 1:00 PM administered by MA B.</p> <p>1 Capsule on 05/05/25 at 7:00 PM, administered by LVN B.</p> <p>The total doses signed out as administered was 2 by MA B.</p> <p>The total doses signed out as administered was 1 by LVN D.</p> <p>The total doses signed out as Wasted was 1 by LVN A.</p> <p>Record Review of the HR File for LVN A revealed that she was employed at the facility from 03/07/25 to 05/05/25. LVN A was terminated from the facility on 05/05/25.</p> <p>Record review of the facility's form titled, Medication/Treatment Unusual Occurrence Report (Medication/Treatment Error) reflected on 05/05/25 during the Day Shift (6am-2pm), LVN A made a Medication Error for Resident #1 for the Lyrica. Resident #1 did not have any adverse reactions to receiving an extra dosage of Lyrica by LVN A. The Actions Taken to Correct the Error included staff In-Service/Reeducation on Medication Administration.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the Correction Action Memo for LVN A and MA B revealed that on 05/05/25 both staff members received a violation for Unsatisfactory Performance and were placed on Suspension. LVN A and MA B were placed on Suspension, pending the facility's investigation regarding the dosages of medication that were given to Resident #1 on 05/05/2025. LVN A and MA B signed the Correction Action Memo on 05/05/25.</p> <p>Record Review of the In-Service Attendance Record for Medication Pass and Administration on 05/05/25. The subjects of the In-Service Training included Medication Pass Expectations, No Pre-Popping of Medications, Hand Hygiene, Resident Observation, Pre-Administration Protocols, MAR/Narcotic Sheet Documentation, and Privacy and Dignity. LVN A did not sign the In-Service Training due to being terminated from the facility. MA B signed the In-Service Training Attendance Sheet on 05/05/2025.</p> <p>An attempted telephone interview with LVN A on 05/21/25 at 11:20 AM was unsuccessful.</p> <p>An attempted telephone interview with LVN A on 05/21/25 at 11:42 AM was unsuccessful.</p> <p>An attempted telephone interview with LVN D on 05/21/25 at 11:45 AM was unsuccessful.</p> <p>In an interview with Resident #1 on 05/22/25 at 12:15 PM, he stated that he had been at the facility for a year. Resident #1 stated that last month (April 2025) he had surgery on his knee which post-surgery has caused him some considerable pain. Resident #1 stated that on 05/05/25, MA B gave him his routine prescriptions of Lyrica (Pregabalin 100 mg) and Oxycodone 10 mg for pain. Resident #1 stated that within an hour of receiving his pain medication from MA B, he put on his Call Light and LVN A came into his room, and he told her that he was in pain and needed some more pain medication. Resident #1 stated that LVN A told him that she would bring him some pain medication and exited his room, Resident #1 stated that some time had passed (unknown time) and LVN A returned to his room and provided him another dosage of his Lyrica (Pregabalin 100 mg) medication. Resident #1 stated that after he received his dosage of Lyrica (Pregabalin 100 mg) medication from LVN A, he realized that he received the same medication within an hour. Resident #1 stated that he then notified ADON C to inform her what occurred. Resident #1 stated that he had a camera in his room and provided the video footage to ADON C of the Medication Administration from LVN A and MA B on 05/05/25. Resident #1 stated that ADON C exited his room and notified the Administrator and both the Administrator and ADON C both returned to his room and viewed the video footage together. Resident #1 stated that after he received the double dosage of his Lyrica (Pregabalin 100 mg) medication, staff notified his PCP and then they were doing observation checks on him for 24 hours. Resident #1 stated that he felt safe at the facility, and he did not experience any harm to his body during his 24-hour Observation. Resident #1 stated that the Administrator apologized for the situation and assured that the situation will not occur again. Resident #1 stated that MA B is currently employed at the facility, but LVN A had not been at the facility since the incident occurred on 05/05/25. Resident #1 stated that the situation involving him receiving an extra dosage of medication was the first and only time since his admission that had occurred. Resident #1 stated that he has not had any issues with his Medication Administration by staff since the incident with LVN A and MA B or any other staff. Resident #1 denied that he abuses his pain medication, and he needs the pain medication to alleviate his pain due to post-surgery for his knee.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with MA B on 05/22/25 at 1:04 PM, she said she had been employed at the facility as a Medication Aide for 3 months. MA B stated she worked the 6:00 AM - 2:00 PM shift with Resident #1 on 05/05/25. She said on 05/05/25, she administered 100 mg Pregabalin (Lyrica) dose to the resident 2 times. She said she documented in the medication administration record and the Narcotic Sheet that she administered the dose on 05/05/25. MA B stated that at 12:00 PM on 05/05/25, she gave Resident #1 his dosage of 100 mg Pregabalin (Lyrica). MA B stated that she gave her key to the Medication cart to LVN A prior to her lunch break. She stated that when she returned from her lunch break, LVN A gave her a Wasted Sign and she signed the Form. MA B stated that although she signed the Wasted Sign, for LVN A, she did not observe LVN A waste the 100 mg Pregabalin (Lyrica) dosage for Resident #1. MA B stated that she did not ask LVN A what she was signing, and she signed that LVN A wasted Resident #1's medication. MA B stated that she later learned that LVN A gave Resident #1 another dosage of Lyrica during her lunch break and wrote Wasted on the Narcotic Administration Record. MA B stated that she and LVN A were suspended while the facility investigated the incident involving Resident #1. MA B stated that the Administrator told her that she knowingly signed something that she did not observe, and she signed for medication that she did not observe LVN A discard. MA B stated that because she is a Certified Medication Aide, a Nurse is supposed to sign the Wasted Buster. MA B stated that she received an In-Service 1:1 Training (a meeting with two individuals, often a manager and employee, meet to discuss work, career development, and progress) for Medication Administration on 05/05/25. MA B stated that the In-Service Training gave directives not to sign anything such as Waste Busters, and there must be 2 Nurses anytime any medications were wasted. MA B stated that MA B stated that prior to 05/05/25, LVN A had never given her any document(s) to sign regarding wasting medication. MA B stated that she was told to return to work at the facility after the facility's investigation of the incident involving Resident #1 and his double dosage of Lyrica on 05/05/25. MA B stated that LVN A did not return to work at the facility after 05/05/25 and was terminated after the incident.</p> <p>In an interview with the Administrator on 05/22/25 at 2:57 PM, she stated that she had been employed at the facility for 3 months. She stated on 05/05/25, the ADON came to her and said that Resident #1 told her that he was administered the same pain medication by LVN A within a 45-minute timeframe of MA B administering the same medication. MA B administered Resident #1 his pain medication of Lyrica prior to going out of the facility for her scheduled lunch break. MA B said that she gave her key to the Medication Cart to LVN A prior to going on her scheduled lunch break. LVN A administered Resident #1 Lyrica during MA B's lunch break. The Administrator stated that Resident #1 received an extra dosage of the narcotic medication of Lyrica due to a verbal communication breakdown between LVN A and MA B. Resident #1 had already received his prescribed pain medication of Lyrica from MA B, who properly signed both the MAR and the Narcotic Count Sheet for Resident #1. The Administrator stated that the resident had a video camera in his room and the video footage revealed that LVN A entered Resident #1's room and Resident #1 requested more pain medication from LVN A due to having some pain issues. LVN A told the resident that she would return with some pain medication and exited Resident #1's room. LVN A did not verify the MAR and the Narcotic Count Sheet and administered Resident #1 an additional dosage of Lyrica, which resulted in Resident #1 receiving an extra dosage of Lyrica. The facility met with MA B and LVN A and both received a Corrective Action for Unsatisfactory Performance due to the medication administration error that occurred with Resident #1's Lyrica medication on 05/05/25. LVN A and MA B were both suspended pending the facility's investigation. Resident #1 was placed on 24-hour monitoring for symptoms of sedation, and/or adverse reactions. Resident #1 did not have any adverse reactions due to receiving 2 dosages of his pain medication of Lyrica that was administered by LVN A on 05/05/25. The facility notified Resident #1's PCP immediately after the incident. Resident #1 was his own RP. The Administrator stated that after the incident involving LVN A and MA B on 05/05/25, the facility did the following:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1.</p> <p>LVN A and MA B involved in the incident were placed on immediate suspension, pending the outcome of the facility's Investigation. MA B returned to work after the investigation was completed. LVN A was terminated after the facility's Investigation due to failure to adhere to the facility's policy of Medication Administration, and being dishonest regarding the medication waste of the medication.</p> <p>2.</p> <p>The facility initiated a full audit on 05/05/25 of all Narcotic Count Sheets from 02/02/25 - 05/05/25 and there were not any concerns.</p> <p>3.</p> <p>In-Service Training with all licensed Nurses and Medication Aides on The Six Rights of Medication Administration, which included:</p> <p>a.</p> <p>Right resident</p> <p>b.</p> <p>Right medication</p> <p>c.</p> <p>Right dose</p> <p>d.</p> <p>Right route</p> <p>e.</p> <p>Right time</p> <p>f.</p> <p>Right documentation</p> <p>4.</p> <p>All staff (including Nurses and Medication Aides) completed a Clinical Competency Validation via a mock Oral Medication Administration demonstration.</p> <p>5.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident Council Meeting was held on 05/05/25 to inform and educate residents on medication safety, including the importance of notifying staff if they have already received a dosage of medication. The residents were also informed and educated on the facility's Medication Management Policy.</p> <p>6.</p> <p>Safe Surveys were conducted with all residents to assess their perceptions of medication safety and confidence in reporting their concerns to staff.</p> <p>7.</p> <p>A new system was implemented and required the DON to be notified prior to any medication(s) being wasted. This change was implemented due to LVN A's admission of providing false information of wasting Resident #1's medication of Lyrica during the facility's investigation.</p> <p>The Administrator stated that the risk of Resident #1 receiving an extra dosage of his Lyrica on 05/05/25 by LVN A was the resident could have an adverse reaction to receiving the extra dosage of medication, such as sedation. The Administrator stated that Resident #1 was under 24-hour observation after the incident, therefore there was no harm caused.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with ADON C on 05/22/25 at 3:36 PM, she stated that she had been employed at the facility for 6 years. ADON C stated that she was the ADON upstairs where Resident #1 is located. ADON C stated that currently she is the ADON downstairs. ADON C stated that on 05/05/25, Resident #1 requested for her to come to speak with him in his room. ADON C stated that Resident #1 has a camera in his room and requested for her to view the Medication Administration for 05/05/25 with LVN A and MA B. ADON C stated that Resident #1's video footage did not have any sound, but they obtained a speaker to listen to the audio on the video footage. The video footage provided by Resident #1 revealed MA B gave Resident #1 his pain medication of Lyrica. ADON C stated that within almost 45 minutes (during MA B's lunch break), LVN A was observed entering his room and speaking to Resident #1. Resident #1 told ADON C that he requested some pain medication from LVN A. LVN A was observed reentering Resident #1's room and administered some medication, which was later discovered to be Lyrica to Resident #1. ADON C stated that she was able to identify LVN A and MA B on the video footage provided by Resident #1. ADON C stated that after reviewing the video footage provided by Resident #1, she notified the Administrator and told her about Resident #1 receiving the double dosage of Lyrica by LVN A and MA B on 05/05/25. ADON stated that LVN A denied that she administered the Lyrica medication to Resident #1 on the video footage provided by Resident #1. LVN A told the Administrator and ADON that she wasted the Lyrica medication for Resident #1 on 05/05/25. ADON C stated that she told LVN A that per the facility's procedures and guidelines, there were to be 2 Nurses present when medication was wasted. ADON C stated that MA B was not a Nurse, and she should have never signed the Wasted Buster. The ADON stated that LVN A and MA B were suspended pending the facility's investigation of the incident. ADON C stated that LVN A was terminated after the incident because she administered the Lyrica medication to Resident #1 but wrote on the log it was wasted and the medication was not wasted. MA B was given a 1:1 In-Service Training on Medication Administration, Guidelines and Procedures. The Nurses and MA's all received the In-Service Training and were quizzed on Medication Administration and all passed their quizzes. ADON said that the MA returned to the facility and is currently employed at the facility. ADON C stated that Resident #1 was his own RP and the staff notified his PCPs about the incident. ADON C stated that Resident #1 seeks pain medication and was only concerned about missing his next dosage of pain medication. ADON C stated that Resident #1 was placed on a 24-hour Observation, and he did not have any adverse s/s during his observation period. ADON C stated that Resident #1 stated that this was a one-time occurrence involving his Medication Administration. ADON C stated that after this incident management has implemented the procedure that required the DON to be notified prior to any medications being wasted. ADON C said that this was a one-time ordeal and the staff have not had any situations such as the one involving Resident #1 receiving an extra dosage of medication. ADON C stated that because Resident #1 was given the same dosage of his pain medication (Lyrica) within an hour, there was a risk of him becoming ill and having some adverse side effects from the medication.</p> <p>An attempted telephone interview with LVN A on 05/22/25 at 5:36 PM was unsuccessful.</p> <p>Record review of the facility's undated policy titled Medication - Administration, reflected:</p> <p>Purpose:</p> <p>To provide practice standards for safe administration of medications for residents in the Facility.</p> <p>Policy:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>I. Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner, or as consistent with state law.</p> <p>II. No medication will be used for any resident other than the resident for whom it was prescribed.</p> <p>III. Medications must be given to the resident by the Licensed Nurse preparing the medication, or as consistent with state law.</p> <p>IV. The licensed nurse must know the following information about any medication they are administering:</p> <p>A. The drug's name (generic and trade)</p> <p>B. The drug's route of administration</p> <p>C. The drug's action</p> <p>D. The drug's indication for use and desired outcome</p> <p>E. The drug's usual dosage</p> <p>F. The drug's side effects and adverse effects</p> <p>G. Any precautions and special considerations</p> <p>V. Medications may be administered one hour before or after the scheduled medication administration time.</p> <p>VI. Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, may be performed as required by state law, and the results recorded.</p> <p>VII. When administration of the drug is dependent upon vital signs or testing, the vital signs/testing will be completed prior to administration of the medication and recorded in the medical record (i.e., BP, pulse, finger stick blood glucose monitoring etc.).</p> <p>VIII. Medications will not be left at the bedside.</p> <p>IX. If the Attending Physician increases or changes a medication order, this is an automatic stop or discontinue order for the original order.</p> <p>X. Safe Handling of Oral Hazardous Drugs - A hazardous drug is any medication possessing at least one of the following characteristics: carcinogenicity, teratogenicity, reproductive toxicity, organ toxicity at low doses, or genotoxicity.</p> <p>A. Pharmacy will alert nursing to hazardous medications by placing a caution label on the medication.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>B. Hand hygiene and use of nitrile gloves during handling of medication will minimize exposure to hazardous drugs.</p> <p>XI. Administration by Unlicensed Personnel - Medications and treatments will be administered only by Licensed Medical or Licensed Nursing Staff .</p> <p>Procedure:</p> <p>. IV. Nursing Staff will keep in mind the seven rights of medication when administering medication:</p> <p>A. The right medication</p> <p>B. The right amount</p> <p>C. The right resident</p> <p>D. The right time</p> <p>E. The right route</p> <p>F. Right indication</p> <p>G. Right outcome</p> <p>V. Additional considerations include:</p> <p>. C. The Rule of 3 - The Licensed Nurse administering medications will perform 3 checks comparing the physician's order, pharmacy label, and Medication Administration Record (MAR).</p> <p>VI. Approach medication preparation task in a calm manner and do not allow for distractions during the process unless under emergent conditions.</p> <p>VII. The resident's MAR will be reviewed for allergies and/or special considerations for administration including:</p> <p>A. Manufacturer's specifications (not recommendations) regarding the preparation and administration of the drug or biological.</p> <p>B. Accepted professional standards and principles.</p> <p>C. Vital sign parameters and lab results as appropriate.</p> <p>VIII. Compare the Licensed Practitioner's prescription/order with the MAR (first check).</p> <p>IX. Compare the Licensed Practitioner's order with the pharmacy label on the medication package</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>(second check).</p> <p>X. Compare the pharmacy label and MAR (third check).</p> <p>XI. Any discrepancies identified during the first, second, and/or third check must be resolved prior to the administration of any medication.</p> <p>XII. Explain the procedure to the resident.</p> <p>XIII. Verify the resident's identity before administering the medication.</p> <p>XIV. Administer the medication to the resident.</p> <p>XV. The Licensed Nurse will remain with the resident until the medicine is actually swallowed.</p> <p>A. If resident is refusing to take medication, the Licensed Nurse who is passing the medications will initial and draw a circle around his/her initials in the designated area on the MAR. Documentation will be entered on the back of the MAR stating the reason for the refusal.</p> <p>B. The Licensed Nurse will re?approach the resident and attempt to give the medications at a later time, but if resident continues to refuse after one hour, the refused medications will be destroyed. Licensed Nurse will notify the Attending Physician and document in the medical record.</p> <p>C. If the resident repeatedly refuses medication, the Licensed Nurse will contact the physician to discuss alternative measures for medication administration. The plan of care will be updated as indicated.</p> <p>XVI. The Licensed Nurse will chart the drug, time administered and initial his/her name with each medication administration and sign full name and title on each page of the MAR .</p> <p>XVII. Holding Medications</p> <p>A. Whenever a medication is held for any reason, the Licensed Nurse will initial the appropriate area on the MAR and circle his/her initials. The Licensed Nurse will document the reason the medication was held on the back of the MAR.</p> <p>XVIII. PRN Medication Documentation</p> <p>A. When a PRN medication is given, it will be documented on the Medication Administration Record. The Nurse will document the date, time, and reason for giving the medication.</p> <p>B. The result or effectiveness of the PRN medication will be charted by the responsible Nurse on the back of the MAR or in the nursing notes.</p> <p>XIX. Documentation</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A. The time and dose of the drug or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the drug or treatment.</p> <p>B. Recording will include the date, the time and the dosage of the medication or type of the treatment.</p> <p>C. Initials may be used, provided that the signature of the person administering the medication or treatment is also recorded on the medication or treatment record.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed ensure residents were free of any significant medication errors for one (Residents #1) of two residents reviewed for medications.</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure LVN A administered medications per the Physician's Orders on 05/05/25 for Resident #1.</li> <li>2. LVN A filled out a wasted form when the medication was not wasted.</li> <li>3. MA B signed the wasted form even though she did not witness LVN A waste the medication.</li> </ol> <p>This failure could place residents at risk for worsening of their medical conditions by not receiving the therapeutic effects of medications prescribed for them, medication error, and drug diversion.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 05/23/25, revealed Resident #1 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. Resident #1's diagnoses included: transient cerebral ischemic attack (a temporary interruption of blood flow to the brain, causing symptoms similar to a stroke but with the symptoms resolving within 24 hours, usually within minutes or hours), osteoarthritis of knee (a degenerative joint disease where the protective cartilage in the knee joint breaks down, causing bones to rub together, resulting in pain, stiffness, and swelling), aftercare following joint replacement surgery, and spinal stenosis (a condition where the spaces within the spine narrow, putting pressure on the spinal cord and nerve roots), idiopathic peripheral autonomic neuropathy (nerve damage in the peripheral nervous system, specifically the autonomic nerves), and low back pain.</p> <p>Record review of Resident #1's MDS assessment, dated 05/04/25, revealed the resident had intact cognitive function with a BIMS score of 15. In Section J - Health Conditions for Pain Management, Resident #1 received a scheduled pain regimen, including PRN pain medications.</p> <p>Record review of Resident #1's Care Plan dated 05/15/25 revealed the following:</p> <p>Focus:</p> <p>[Resident #1] had diagnosis of narcotic dependence.</p> <p>[Resident #1] will say he did not receive pain med after it has been administered, and where corrected will say he'll watch it on video .</p> <p>Date Initiated: 04/29/2025</p> <p>Revision on: 05/01/2025</p> <p>Goal:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>[Resident #1] will verbalize awareness of the relationship between substance abuse and the current situation by next review date.</p> <p>Date Initiated: 04/29/2025</p> <p>Target Date: 05/07/2025</p> <p>Interventions/Tasks:</p> <p>Educate [Resident #1] on risks of narcotic abuse.</p> <p>Date Initiated: 04/29/2025</p> <p>Pain management consult.</p> <p>Date Initiated: 04/29/2025</p> <p>Psych consult.</p> <p>Date Initiated: 04/29/2025</p> <p>Focus:</p> <p>[Resident #1] required pain management D/T osteoarthritis, joint replacement, spinal stenosis, lower back pain, and neuropathy.</p> <p>4/5/25 - Resident readmitted to facility post-surgery.</p> <p>Date Initiated: 04/30/2025</p> <p>Revision on: 05/15/2025</p> <p>Goal:</p> <p>[Resident #1] will display a decrease in behaviors of inadequate pain control example irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, groaning, crying through the review date.</p> <p>Date Initiated: 04/30/2025</p> <p>Revision on: 05/01/2025</p> <p>Target Date: 05/07/2025</p> <p>[Resident #1] will not have discomfort related to side effects of analgesia through the review date.</p> <p>Date Initiated: 05/01/2025</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Revision on: 05/01/2025</p> <p>Target Date: 05/07/2025</p> <p>Interventions/Tasks:</p> <p>Administer analgesia (pain) medication as per orders. Give 1/2 hour before treatments or care.</p> <p>Date Initiated: 04/30/2025</p> <p>Anticipate the resident's need for pain relief and respond immediately to any complaint of pain.</p> <p>Date Initiated: 04/30/2025</p> <p>Revision on: 05/01/2025</p> <p>Evaluate the effectiveness of pain interventions (FREQ). Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.</p> <p>Date Initiated: 04/30/2025</p> <p>Revision on: 05/01/2025 .</p> <p>Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment.</p> <p>Date Initiated: 04/30/2025</p> <p>Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care.</p> <p>Date Initiated: 04/30/2025 .</p> <p>Record review of Resident #1' s Physician Order Summary Report, dated May 2025 reflected:</p> <p>05/01/25 Pregabalin Oral Capsule 300 MG (Pregabalin) (generic for Lyrica), give 1 tablet by mouth three times a day for idiopathic peripheral autonomic neuropathy.</p> <p>Record review of Resident #1's Medication Administration Record (MAR) dated May 2025 reflected:</p> <p>05/05/25 Pregabalin Oral Capsule 300 MG (Pregabalin)</p> <p>Give 1 capsule by mouth three times a day related to OTHER</p> <p>IDIOPATHIC PERIPHERAL</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>AUTONOMIC NEUROPATHY .</p> <p>-Order Date-</p> <p>05/01/2025</p> <p>The MAR revealed:</p> <p>1 Capsule on 05/05/25 at 7:00 AM administered by MA B.</p> <p>1 Capsule on 05/05/25 at 1:00 PM administered by MA B.</p> <p>1 Capsule on 05/05/25 at 7:00 PM administered by LVN D.</p> <p>Record review of Resident #1's Narcotic Record for Pregabalin 100 mg CAP (generic for Lyrica) reflected the resident was ordered to receive 1 Capsule by mouth three times a day. The resident received the following doses of Pregabalin 100 mg CAP:</p> <p>1 Capsule on 05/05/25 at 7:00 AM administered by MA B.</p> <p>1 Capsule on 05/05/25 at 1:00 PM administered by MA B.</p> <p>1 Capsule on 05/05/25 at 7:00 PM, administered by LVN B.</p> <p>The total doses signed out as administered was 2 by MA B.</p> <p>The total doses signed out as administered was 1 by LVN D.</p> <p>The total doses signed out as Wasted was 1 by LVN A.</p> <p>Record Review of the HR File for LVN A revealed that she was employed at the facility from 03/07/25 to 05/05/25. LVN A was terminated from the facility on 05/05/25.</p> <p>Record review of the facility's form titled, Medication/Treatment Unusual Occurrence Report (Medication/Treatment Error) reflected on 05/05/25 during the Day Shift (6am-2pm), LVN A made a Medication Error for Resident #1 for the Lyrica. Resident #1 did not have any adverse reactions to receiving an extra dosage of Lyrica by LVN A. The Actions Taken to Correct the Error included staff In-Service/Reeducation on Medication Administration.</p> <p>Record review of the Correction Action Memo for LVN A and MA B revealed that on 05/05/25 both staff members received a violation for Unsatisfactory Performance and were placed on Suspension. LVN A and MA B were placed on Suspension, pending the facility's investigation regarding the dosages of medication that were given to Resident #1 on 05/05/2025. LVN A and MA B signed the Correction Action Memo on 05/05/25.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record Review of the In-Service Attendance Record for Medication Pass and Administration on 05/05/25. The subjects of the In-Service Training included Medication Pass Expectations, No Pre-Popping of Medications, Hand Hygiene, Resident Observation, Pre-Administration Protocols, MAR/Narcotic Sheet Documentation, and Privacy and Dignity. LVN A did not sign the In-Service Training due to being terminated from the facility. MA B signed the In-Service Training Attendance Sheet on 05/05/2025.</p> <p>An attempted telephone interview with LVN A on 05/21/25 at 11:20 AM was unsuccessful.</p> <p>An attempted telephone interview with LVN A on 05/21/25 at 11:42 AM was unsuccessful.</p> <p>An attempted telephone interview with LVN D on 05/21/25 at 11:45 AM was unsuccessful.</p> <p>In an interview with Resident #1 on 05/22/25 at 12:15 PM, he stated that he had been at the facility for a year. Resident #1 stated that last month (April 2025) he had surgery on his knee which post-surgery has caused him some considerable pain. Resident #1 stated that on 05/05/25, MA B gave him his routine prescriptions of Lyrica (Pregabalin 100 mg) and Oxycodone 10 mg for pain. Resident #1 stated that within an hour of receiving his pain medication from MA B, he put on his Call Light and LVN A came into his room, and he told her that he was in pain and needed some more pain medication. Resident #1 stated that LVN A told him that she would bring him some pain medication and exited him room, Resident #1 stated that some time had passed (unknown time) and LVN A returned to his room and provided him another dosage of his Lyrica (Pregabalin 100 mg) medication. Resident #1 stated that after he received his dosage of Lyrica (Pregabalin 100 mg) medication from LVN A, he realized that he received the same medication within an hour. Resident #1 stated that he then notified ADON C to inform her what occurred. Resident #1 stated that he had a camera in his room and provided the video footage to ADON C of the Medication Administration from LVN A and MA B on 05/05/25. Resident #1 stated that ADON C exited his room and notified the Administrator and both the Administrator and ADON C both returned to his room and viewed the video footage together. Resident #1 stated that after he received the double dosage of his Lyrica (Pregabalin 100 mg) medication, staff notified his PCP and then they were doing observation checks on him for 24 hours. Resident #1 stated that he felt safe at the facility, and he did not experience any harm to his body during his 24-hour Observation. Resident #1 stated that the Administrator apologized for the situation and assured that the situation will not occur again. Resident #1 stated that MA B is currently employed at the facility, but LVN A had not been at the facility since the incident occurred on 05/05/25. Resident #1 stated that the situation involving him receiving an extra dosage of medication was the first and only time since his admission that had occurred. Resident #1 stated that he has not had any issues with his Medication Administration by staff since the incident with LVN A and MA B or any other staff. Resident #1 denied that he abuses his pain medication, and he needs the pain medication to alleviate his pain due to post-surgery for his knee.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with MA B on 05/22/25 at 1:04 PM, she said she had been employed at the facility as a Medication Aide for 3 months. MA B stated she worked the 6:00 AM - 2:00 PM shift with Resident #1 on 05/05/25. She said on 05/05/25, she administered 100 mg Pregabalin (Lyrica) dose to the resident 2 times. She said she documented in the medication administration record and the Narcotic Sheet that she administered the dose on 05/05/25. MA B stated that at 12:00 PM on 05/05/25, she gave Resident #1 his dosage of 100 mg Pregabalin (Lyrica). MA B stated that she gave her key to the Medication cart to LVN A prior to her lunch break. She stated that when she returned from her lunch break, LVN A gave her a Wasted Sign and she signed the Form. MA B stated that although she signed the Wasted Sign, for LVN A, she did not observe LVN A waste the 100 mg Pregabalin (Lyrica) dosage for Resident #1. MA B stated that she did not ask LVN A what she was signing, and she signed that LVN A wasted Resident #1's medication. MA B stated that she later learned that LVN A gave Resident #1 another dosage of Lyrica during her lunch break and wrote Wasted on the Narcotic Administration Record. MA B stated that she and LVN A were suspended while the facility investigated the incident involving Resident #1. MA B stated that the Administrator told her that she knowingly signed something that she did not observe, and she signed for medication that she did not observe LVN A discard. MA B stated that because she is a Certified Medication Aide, a Nurse is supposed to sign the Wasted Buster. MA B stated that she received an In-Service 1:1 Training (a meeting with two individuals, often a manager and employee, meet to discuss work, career development, and progress) for Medication Administration on 05/05/25. MA B stated that the In-Service Training gave directives not to sign anything such as Waste Busters, and there must be 2 Nurses anytime any medications were wasted. MA B stated that MA B stated that prior to 05/05/25, LVN A had never given her any document(s) to sign regarding wasting medication. MA B stated that she was told to return to work at the facility after the facility's investigation of the incident involving Resident #1 and his double dosage of Lyrica on 05/05/25. MA B stated that LVN A did not return to work at the facility after 05/05/25 and was terminated after the incident.</p> <p>In an interview with the Administrator on 05/22/25 at 2:57 PM, she stated that she had been employed at the facility for 3 months. She stated on 05/05/25, the ADON came to her and said that Resident #1 told her that he was administered the same pain medication by LVN A within a 45-minute timeframe of MA B administering the same medication. MA B administered Resident #1 his pain medication of Lyrica prior to going out of the facility for her scheduled lunch break. MA B said that she gave her key to the Medication Cart to LVN A prior to going on her scheduled lunch break. LVN A administered Resident #1 Lyrica during MA B's lunch break. The Administrator stated that Resident #1 received an extra dosage of the narcotic medication of Lyrica due to a verbal communication breakdown between LVN A and MA B. Resident #1 had already received his prescribed pain medication of Lyrica from MA B, who properly signed both the MAR and the Narcotic Count Sheet for Resident #1. The Administrator stated that the resident had a video camera in his room and the video footage revealed that LVN A entered Resident #1's room and Resident #1 requested more pain medication from LVN A due to having some pain issues. LVN A told the resident that she would return with some pain medication and exited Resident #1's room. LVN A did not verify the MAR and the Narcotic Count Sheet and administered Resident #1 an additional dosage of Lyrica, which resulted in Resident #1 receiving an extra dosage of Lyrica. The facility met with MA B and LVN A and both received a Corrective Action for Unsatisfactory Performance due to the medication administration error that occurred with Resident #1's Lyrica medication on 05/05/25. LVN A and MA B were both suspended pending the facility's investigation. Resident #1 was placed on 24-hour monitoring for symptoms of sedation, and/or adverse reactions. Resident #1 did not have any adverse reactions due to receiving 2 dosages of his pain medication of Lyrica that was administered by LVN A on 05/05/25. The facility notified Resident #1's PCP immediately after the incident. Resident #1 was his own RP. The Administrator stated that after the incident involving LVN A and MA B on 05/05/25, the facility did the following:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1.</p> <p>LVN A and MA B involved in the incident were placed on immediate suspension, pending the outcome of the facility's Investigation. MA B returned to work after the investigation was completed. LVN A was terminated after the facility's Investigation due to failure to adhere to the facility's policy of Medication Administration, and being dishonest regarding the medication waste of the medication.</p> <p>2.</p> <p>The facility initiated a full audit on 05/05/25 of all Narcotic Count Sheets from 02/02/25 - 05/05/25 and there were not any concerns.</p> <p>3.</p> <p>In-Service Training with all licensed Nurses and Medication Aides on The Six Rights of Medication Administration, which included:</p> <p>a.</p> <p>Right resident</p> <p>b.</p> <p>Right medication</p> <p>c.</p> <p>Right dose</p> <p>d.</p> <p>Right route</p> <p>e.</p> <p>Right time</p> <p>f.</p> <p>Right documentation</p> <p>4.</p> <p>All staff (including Nurses and Medication Aides) completed a Clinical Competency Validation via a mock Oral Medication Administration demonstration.</p> <p>5.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  18648 Hillcrest Rd Dallas, TX 75252	
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident Council Meeting was held on 05/05/25 to inform and educate residents on medication safety, including the importance of notifying staff if they have already received a dosage of medication. The residents were also informed and educated on the facility's Medication Management Policy.</p> <p>6.</p> <p>Safe Surveys were conducted with all residents to assess their perceptions of medication safety and confidence in reporting their concerns to staff.</p> <p>7.</p> <p>A new system was implemented and required the DON to be notified prior to any medication(s) being wasted. This change was implemented due to LVN A's admission of providing false information of wasting Resident #1's medication of Lyrica during the facility's investigation.</p> <p>The Administrator stated that the risk of Resident #1 receiving an extra dosage of his Lyrica on 05/05/25 by LVN A was the resident could have an adverse reaction to receiving the extra dosage of medication, such as sedation. The Administrator stated that Resident #1 was under 24-hour observation after the incident, therefore there was no harm caused.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with ADON C on 05/22/25 at 3:36 PM, she stated that she had been employed at the facility for 6 years. ADON C stated that she was the ADON upstairs where Resident #1 is located. ADON C stated that currently she is the ADON downstairs. ADON C stated that on 05/05/25, Resident #1 requested for her to come to speak with him in his room. ADON C stated that Resident #1 has a camera in his room and requested for her to view the Medication Administration for 05/05/25 with LVN A and MA B. ADON C stated that Resident #1's video footage did not have any sound, but they obtained a speaker to listen to the audio on the video footage. The video footage provided by Resident #1 revealed MA B gave Resident #1 his pain medication of Lyrica. ADON C stated that within almost 45 minutes (during MA B's lunch break), LVN A was observed entering his room and speaking to Resident #1. Resident #1 told ADON C that he requested some pain medication from LVN A. LVN A was observed reentering Resident #1's room and administered some medication, which was later discovered to be Lyrica to Resident #1. ADON C stated that she was able to identify LVN A and MA B on the video footage provided by Resident #1. ADON C stated that after reviewing the video footage provided by Resident #1, she notified the Administrator and told her about Resident #1 receiving the double dosage of Lyrica by LVN A and MA B on 05/05/25. ADON stated that LVN A denied that she administered the Lyrica medication to Resident #1 on the video footage provided by Resident #1. LVN A told the Administrator and ADON that she wasted the Lyrica medication for Resident #1 on 05/05/25. ADON C stated that she told LVN A that per the facility's procedures and guidelines, there were to be 2 Nurses present when medication was wasted. ADON C stated that MA B was not a Nurse, and she should have never signed the Wasted Buster. The ADON stated that LVN A and MA B were suspended pending the facility's investigation of the incident. ADON C stated that LVN A was terminated after the incident because she administered the Lyrica medication to Resident #1 but wrote on the log it was wasted and the medication was not wasted. MA B was given a 1:1 In-Service Training on Medication Administration, Guidelines and Procedures. The Nurses and MA's all received the In-Service Training and were quizzed on Medication Administration and all passed their quizzes. ADON said that the MA returned to the facility and is currently employed at the facility. ADON C stated that Resident #1 was his own RP and the staff notified his PCPs about the incident. ADON C stated that Resident #1 seeks pain medication and was only concerned about missing his next dosage of pain medication. ADON C stated that Resident #1 was placed on a 24-hour Observation, and he did not have any adverse s/s during his observation period. ADON C stated that Resident #1 stated that this was a one-time occurrence involving his Medication Administration. ADON C stated that after this incident management has implemented the procedure that required the DON to be notified prior to any medications being wasted. ADON C said that this was a one-time ordeal and the staff have not had any situations such as the one involving Resident #1 receiving an extra dosage of medication. ADON C stated that because Resident #1 was given the same dosage of his pain medication (Lyrica) within an hour, there was a risk of him becoming ill and having some adverse side effects from the medication.</p> <p>An attempted telephone interview with LVN A on 05/22/25 at 5:36 PM was unsuccessful.</p> <p>Record review of the facility's undated policy titled Medication - Administration, reflected:</p> <p>Purpose:</p> <p>To provide practice standards for safe administration of medications for residents in the Facility.</p> <p>Policy:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>I. Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner, or as consistent with state law.</p> <p>II. No medication will be used for any resident other than the resident for whom it was prescribed.</p> <p>III. Medications must be given to the resident by the Licensed Nurse preparing the medication, or as consistent with state law.</p> <p>IV. The licensed nurse must know the following information about any medication they are administering:</p> <p>A. The drug's name (generic and trade)</p> <p>B. The drug's route of administration</p> <p>C. The drug's action</p> <p>D. The drug's indication for use and desired outcome</p> <p>E. The drug's usual dosage</p> <p>F. The drug's side effects and adverse effects</p> <p>G. Any precautions and special considerations</p> <p>V. Medications may be administered one hour before or after the scheduled medication administration time.</p> <p>VI. Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, may be performed as required by state law, and the results recorded.</p> <p>VII. When administration of the drug is dependent upon vital signs or testing, the vital signs/testing will be completed prior to administration of the medication and recorded in the medical record (i.e., BP, pulse, finger stick blood glucose monitoring etc.).</p> <p>VIII. Medications will not be left at the bedside.</p> <p>IX. If the Attending Physician increases or changes a medication order, this is an automatic stop or discontinue order for the original order.</p> <p>X. Safe Handling of Oral Hazardous Drugs - A hazardous drug is any medication possessing at least one of the following characteristics: carcinogenicity, teratogenicity, reproductive toxicity, organ toxicity at low doses, or genotoxicity.</p> <p>A. Pharmacy will alert nursing to hazardous medications by placing a caution label on the medication.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>B. Hand hygiene and use of nitrile gloves during handling of medication will minimize exposure to hazardous drugs.</p> <p>XI. Administration by Unlicensed Personnel - Medications and treatments will be administered only by Licensed Medical or Licensed Nursing Staff .</p> <p>Procedure:</p> <p>. IV. Nursing Staff will keep in mind the seven rights of medication when administering medication:</p> <p>A. The right medication</p> <p>B. The right amount</p> <p>C. The right resident</p> <p>D. The right time</p> <p>E. The right route</p> <p>F. Right indication</p> <p>G. Right outcome</p> <p>V. Additional considerations include:</p> <p>. C. The Rule of 3 - The Licensed Nurse administering medications will perform 3 checks comparing the physician's order, pharmacy label, and Medication Administration Record (MAR).</p> <p>VI. Approach medication preparation task in a calm manner and do not allow for distractions during the process unless under emergent conditions.</p> <p>VII. The resident's MAR will be reviewed for allergies and/or special considerations for administration including:</p> <p>A. Manufacturer's specifications (not recommendations) regarding the preparation and administration of the drug or biological.</p> <p>B. Accepted professional standards and principles.</p> <p>C. Vital sign parameters and lab results as appropriate.</p> <p>VIII. Compare the Licensed Practitioner's prescription/order with the MAR (first check).</p> <p>IX. Compare the Licensed Practitioner's order with the pharmacy label on the medication package</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>(second check).</p> <p>X. Compare the pharmacy label and MAR (third check).</p> <p>XI. Any discrepancies identified during the first, second, and/or third check must be resolved prior to the administration of any medication.</p> <p>XII. Explain the procedure to the resident.</p> <p>XIII. Verify the resident's identity before administering the medication.</p> <p>XIV. Administer the medication to the resident.</p> <p>XV. The Licensed Nurse will remain with the resident until the medicine is actually swallowed.</p> <p>A. If resident is refusing to take medication, the Licensed Nurse who is passing the medications will initial and draw a circle around his/her initials in the designated area on the MAR. Documentation will be entered on the back of the MAR stating the reason for the refusal.</p> <p>B. The Licensed Nurse will re?approach the resident and attempt to give the medications at a later time, but if resident continues to refuse after one hour, the refused medications will be destroyed. Licensed Nurse will notify the Attending Physician and document in the medical record.</p> <p>C. If the resident repeatedly refuses medication, the Licensed Nurse will contact the physician to discuss alternative measures for medication administration. The plan of care will be updated as indicated.</p> <p>XVI. The Licensed Nurse will chart the drug, time administered and initial his/her name with each medication administration and sign full name and title on each page of the MAR .</p> <p>XVII. Holding Medications</p> <p>A. Whenever a medication is held for any reason, the Licensed Nurse will initial the appropriate area on the MAR and circle his/her initials. The Licensed Nurse will document the reason the medication was held on the back of the MAR.</p> <p>XVIII. PRN Medication Documentation</p> <p>A. When a PRN medication is given, it will be documented on the Medication Administration Record. The Nurse will document the date, time, and reason for giving the medication.</p> <p>B. The result or effectiveness of the PRN medication will be charted by the responsible Nurse on the back of the MAR or in the nursing notes.</p> <p>XIX. Documentation</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A. The time and dose of the drug or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the drug or treatment.</p> <p>B. Recording will include the date, the time and the dosage of the medication or type of the treatment.</p> <p>C. Initials may be used, provided that the signature of the person administering the medication or treatment is also recorded on the medication or treatment record.</p>		