| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| SILVER BIRCH OF TERRE HAUTE | 650 LAFAYETTE AVENUE<br>TERRE HAUTE, IN 47807 |

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| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey.<br><br>Survey dates: September 22 and 23, 2022<br><br>Facility number: 014291<br><br>Residential Census: 90<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on October 7, 2022. | R 0000 | This plan of correction is submitted as required under federal and state regulation. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.<br>Please accept this plan of correction as our credible allegation of compliance. We are requesting a desk review for paper compliance. | |
| R 0117<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(b)<br>Personnel - Deficiency<br>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services | | | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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| | or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.<br><br>Based on record review and interview, the facility failed to ensure a minimum of one staff person was CPR (cardiopulmonary resuscitation-an emergency procedure consisting of chest compressions often combined with artificial ventilation in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person who is in cardiac arrest) and first aid certified during a night shift for 1 of 7 scheduled days reviewed.<br><br>Findings include:<br><br>On 9/22/22 at 2:00 p.m., staffing schedules were reviewed to ensure at least one on-duty staff member was both CPR and first aid certified. During the night shift of 9/16/22, the schedule indicated Certified Nursing Assistant (CNA) 8 and CNA 9 had worked the night shift. Review of the facility's CPR and first aid certifications indicated CNA 8 had CPR certification but lacked documentation of the CNA being certified in first aid. The certifications lacked documentation that CNA 9 had been certified in either CPR or first aid.<br><br>During an interview, on 9/22/22 at 2:22 p.m., the | R 0117 | It is the practice of this community to ensure a minimum of one (1) awake staff person with current CPR/First Aid certification is on site at all times.<br>**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>No residents were identified as being affected.<br><br>CNA 9 is scheduled to complete the CPR/First Aid course on 10/25/2022. When CNA 9 is scheduled to work another staff member with current certification in CPR/First Aid will be scheduled to work with her.<br><br>**2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents have the potential to | 11/22/2022 |

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| | Director of Nursing (DON) indicated two CNAs worked the night shift of 9/16/22. CNA 9 was a new employee and had been signed up to take the CPR and first aid course, but the course had not yet been held. CNA 8 had no-called/no-showed for her last shift, and her employment had been terminated. The DON had attempted to contact CNA 8 to find out if she had been certified in first aid and had just not provided the facility with her certification card. She left the CNA a message but had not received a return call. She was not able to provide verification that CNA 9 had a first aid certification at the time she had worked on 9/16/22. The DON was unsure if the facility had a policy specific to the requirement for staff to be fully certified in both CPR and first aid in order to work. She indicated she was aware of the residential regulation and the facility would be expected to follow all residential regulations.<br><br>The Indiana Residential Regulation, dated 2008, 410 IAC 16.2-5-1.4(b) indicated, "...A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times...." | | be affected by the alleged deficient practice.<br><br>The staff schedule will indicate staff that are CPR/First Aid certified as indicated by a highlight. At least one staff person that is CPR/First Aid certified will be scheduled every shift.<br><br>The Director of Nursing and Wellness and Executive Director will educate all staff on their responsibility to keep their CPR/First Aid certification current and to report to their manager if they need assistance in finding a location to complete or renew their certification.<br><br>**3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br>The Human Resource representative will request proof of CPR and first aid completion upon hire. Any staff person that does not hold a current CPR/First Aid certification will be provided an opportunity to obtain the certification within the first 45 days of hire.<br>The Director of Nursing and Wellness or designee will review the schedule daily for 4 weeks, then weekly for 4 weeks, then randomly ongoing to ensure at | |

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| | | | least one staff with current CPR/First Aid certification is present every shift. Any findings will be corrected at the time of discovery.<br>The HR representative or designee will conduct audits of personnel files to ensure a current CPR/First Aid certification is present 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then monthly x 4 months, then quarterly ongoing. Any findings will be addressed at the time of discovery.<br><br>**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The Director of Nursing and Wellness will report findings and/or trends in noncompliance of having at least one CPR/First Aid certified staff on every shift to the Quality Assurance Committee monthly until 100% compliance has been met for 3 consecutive months, then quarterly ongoing.<br>The HR representative or designee will report findings and/ or trends in noncompliance of staff certification in CPR/First Aid, including corrective actions and training provided to the QA Committee for discussion and further recommendations. Audits will continue quarterly ongoing. | |

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| | | | **5. By what date the systemic changes will be completed?**<br>11/22/2022 | |
| R 0241<br><br>Bldg. 00 | 410 IAC 16.2-5-4(e)(1)<br>Health Services - Offense<br>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows:<br>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.<br>Based on observation, record review, and interview, the facility failed to ensure medication administration was supervised for 5 of 5 residents reviewed during medication pass (Residents 314, 301, 375, 307, and 330), to ensure a medication was administered at the correct time (Resident 307), and to ensure a resident took her morning medications as ordered during 1 of 1 random observations (Resident 314).<br><br>Findings include:<br><br>1. During a continuous medication pass observation, on 9/22/22 from 10:40 a.m. to 10:58 a.m., Qualified Medication Aide (QMA) 4 was observed passing medications. QMA 4 prepared hydralazine (a blood pressure medication) 25 milligrams (mg) 1 tablet, and took it to Resident 314's room. Resident 314 was not in the room. QMA 4 placed the medication cup on the table, and indicated she was not sure where the resident was or when she would be back, but she would take the medication when she returned to her room. She was allowed to leave medications | R 0241 | **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident 301: Medication Self-Administration Assessment, Level of Service Assessment, and BIMS Cognitive assessment were completed on 10/21/22 to determine resident's ability to take medications left in apartment when resident is not present. It has been determined that resident's medications will be left in apartment if resident is not present per physician's order, at the time of med pass by a Licensed nurse or QMA.<br>Resident 307: Medication Self-Administration Assessment, Level of Service Assessment, and BIMS Cognitive assessment were completed on 10/21/22 to | 10/23/2022 |

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| | unattended in the resident's rooms unless there was a physician's order which indicated to not leave the medications at bedside, She would not need to go back to ensure the resident took the medication. QMA 4 prepared gabapentin (a medication for nerve pain) 300 mg 1 capsule, and took it to Resident 301's room. Resident 301 was not in the room. QMA 4 placed the medication cup on the resident's table, and indicated the resident went to a skilled nursing facility (SNF) to visit his wife and would take the medication when he returned to the facility around lunch time. QMA 4 prepared gabapentin 300 mg 1 capsule, and took it to Resident 375's room. Resident 375 was not in the room. QMA 4 placed the medication cup on the resident's table, and indicated she was not sure where the resident was or when he would be back, but he would take the medication when he returned to his room. QMA 4 prepared Percocet (a narcotic pain medication) 10/325 mg 1 tablet and diazepam (an antianxiety medication) 2 mg 1 tablet, and took it to Resident 307's room. Resident 307 was lying in bed. QMA 4 placed the medication cup on the resident's bedside table and left the room without observing if the resident took the medications. QMA 4 prepared buspirone (an antianxiety medication) 15 mg 1 tablet, clonidine (a blood pressure medication) 0.1 mg 1 tablet, and tramadol (a narcotic pain medication) 50 mg 1 tablet, and took it to Resident 330's room. QMA 4 placed the medications on the resident's table and left the room without observing if the resident took the medications.<br><br>a. Resident 330's record was reviewed on 9/23/22 at 9:00 a.m. Diagnoses on the resident's profile included, but were not limited to, generalized anxiety disorder, essential hypertension (high blood pressure), and pain in unspecified joint. | | determine resident's ability to take medications left in apartment when resident is not present. It has been determined that resident's medications will not be left in apartment and resident will be observed taking medications at the time of med pass by a Licensed nurse or QMA.<br>Resident 314: Medication Self-Administration Assessment, Level of Service Assessment, and BIMS Cognitive assessment were completed on 10/21/22 to determine resident's ability to take medications left in apartment when resident is not present. It has been determined that resident's medications will be left in apartment if resident is not present per physician's order, at the time of med pass by a Licensed nurse or QMA.<br>Resident 330: Medication Self-Administration Assessment, Level of Service Assessment, and BIMS Cognitive assessment were completed on 10/21/22 to determine resident's ability to take medications left in apartment when resident is not present. It has been determined that resident's medications will not be left in apartment and resident will be observed taking medications at the time of med pass by a Licensed nurse or QMA.<br>Resident 375: Medication Self-Administration Assessment, Level of Service Assessment, and | |

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| | A brief interview for mental status (BIMS) (an assessment to determine cognition level), dated 6/9/21, indicated the resident was cognitively intact.<br><br>A level of service assessment, dated 9/16/22, indicated the resident exhibited poor judgement as evidenced by decisions were poor, required cueing and supervision in planning, organizing and correcting daily routines. The resident required caregiver administration and/or observation of medications requiring judgement for necessity, dosage, and/or effect, and this was a round the clock need. The medication plan included, but was not limited to, a specific goal resident will be watched while taking medications at all times, will be supported to take all medications safely and as ordered. Interventions included, but were not limited to, required daily supervision of medications.<br><br>A medication service plan, last revised 9/7/22, indicated the resident would be watched while taking medications at all times and would be supported to take all medications safely and as ordered. Interventions included, but were not limited to, required daily supervision of medication.<br><br>A physician's order, dated 9/16/22, indicated monitor resident completely takes medications two times a day for medication management.<br><br>A physician's order, dated 9/16/22, indicated buspirone 15 mg by mouth 3 times daily related to generalized anxiety disorder.<br><br>A physician's order, dated 9/16/22, indicated clonidine 0.1 mg by mouth 3 times daily related to | | BIMS Cognitive assessment were completed on 10/21/22 to determine resident's ability to take medications left in apartment when resident is not present. It has been determined that resident's medications will be left in apartment if resident is not present per physician's order, at the time of med pass by a Licensed nurse or QMA.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**<br>All residents residing at Silver Birch of Terre Haute have the potential to be affected by the alleged deficient practice.<br>QMA 4 received 1:1 re-education by the Director of Nursing and Wellness on proper medication administration including observation of the resident taking medications and not leaving medications in a resident's apartment when the resident is not present.<br>All Nursing staff have been re-educated by the Director of Nursing and Wellness on proper medication administration including observation of the resident taking medications and not leaving medications in a resident's apartment when the resident is not present. | |

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| | essential hypertension.<br><br>A physician's order, dated 9/16/22, indicated tramadol 50 mg 1 tablet by mouth every 6 hours as needed for chronic pain related to pain in unspecified joint.<br><br>The record lacked documentation of an assessment of self administration of medication.<br><br>b. Resident 301's record was reviewed on 9/23/22 at 9:15 a.m. Diagnoses on the resident's profile included, but were not limited to, other idiopathic peripheral (away from the center) autonomic neuropathy (damage of the peripheral nerves where cause can not be determined).<br><br>A physician's order, dated 2/23/21, indicated gabapentin 300 mg 1 capsule, by mouth 3 times daily for other idiopathic peripheral autonomic neuropathy.<br><br>A BIMS assessment, dated 7/6/21, indicated the resident was cognitively intact.<br><br>A level of service assessment, dated 8/31/22, indicated the resident's cognition plan included documentation the resident demonstrated inappropriate judgement related to safety. The resident required caregiver administration and/or observation of medications requiring judgement for necessity, dosage and/or effect. This was a round the clock need. The resident would be supported to take all medications safely and as ordered and required daily supervision of medications.<br><br>A medication service plan, last revised 9/19/22, indicated the resident would be supported to take all medications safely and as ordered. | | Non-licensed or certified staff have been educated on immediate reporting to the Director of Nursing and Wellness or designee if medications are found in a resident's apartment and the resident is not present. The Director of Nursing and Wellness or designee will address any reports of medications left in an apartment without the resident present at the time of the report.<br><br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;**<br>The Director of Nursing and Wellness or designee will observe med pass and check resident apartments for medications left when residents were not present. Med pass observations will take place daily times 4 weeks, then weekly times 4 weeks, then monthly until 100% compliance has been met for 3 consecutive months, then quarterly ongoing. Any findings will be documented on an audit tool and will be addressed at the time of discovery.<br><br>**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put** | |

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| | The record lacked documentation of an assessment of self administration of medication.<br><br>c. Resident 307's record was reviewed on 9/23/22 at 9:20 a.m. Diagnoses on the resident's profile included, but were not limited to, anxiety disorder unspecified and altered mental status unspecified.<br><br>A BIMS assessment, dated 8/19/21, indicated the resident was cognitively intact.<br><br>A physician's order, dated 3/23/22, indicated diazepam 2 mg 1 tablet by mouth, three times daily for anxiety. The administrations were scheduled for 7:00 a.m., 3:00 p.m., and 8:00 p.m., and lacked documentation of a scheduled administration during the time of the medication pass observation.<br><br>A physician's order, dated 6/10/22, indicated Percocet 10/325 mg 1 tablet, by mouth 4 times daily for pain.<br><br>A level of service assessment, dated 8/19/22, indicated the resident had a dementia diagnosis and/or significant memory loss combined with behaviors, demonstrated inappropriate judgement related to safety, and displayed deficits in judgement. The resident required caregiver administration and/or observation of medications requiring judgement for necessity, dosage and/or effect, would be supported to take all medication safely and as ordered, needed help with medications due to cognitive loss, and was unable to self-administer pre-poured medications.<br><br>A medication service plan, last revised 8/29/22, indicated the resident would be supported to take all medications safely and as ordered. | | **into place;**<br>The Director of Nursing and Wellness will report audit findings to the Quality Assurance Committee monthly for discussion of needed interventions until 100% compliance has been reached for 3 consecutive months, then quarterly ongoing.<br><br>**What date the systemic changes will be completed:**<br>Completion date: 10/23/22 | |

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| | Interventions included, but were not limited to, required help with medications due to cognitive loss and unable to self-administer pre-poured medications.<br><br>The record lacked documentation of an assessment of self administration of medication.<br><br>During an interview, on 9/23/22 at 9:44 a.m., the Director of Nursing (DON) indicated Resident 307's diazepam should have been administered an hour before or an hour after the scheduled administration times. It was not administered at the correct time.<br><br>d. Resident 375's record was reviewed on 9/23/22 at 9:25 a.m. Diagnoses on the resident's profile included, but were not limited to, low back pain and altered mental status unspecified.<br><br>A BIMS assessment, dated 6/22/21, indicated the resident was cognitively intact.<br><br>A physician's order, dated 11/7/21, indicated gabapentin 300 mg 1 capsule by mouth, 3 times a day for back pain.<br><br>A level of service assessment, dated 6/22/22, indicated the resident's decisions were poor and required cueing and supervision in planning, organizing and correcting daily routines. The resident had a dementia diagnosis and/or significant memory loss combined with behaviors. The resident required caregiver administration and/or observation of medications requiring judgement for necessity, dosage and/or effect, and required daily supervision of medications. This was a round the clock need.<br><br>The record lacked documentation of a medication | | | |

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| | service plan or an assessment of self administration of medication.<br><br>During an interview, on 9/22/22 at 11:24 a.m., the DON indicated if a resident was alert and oriented and gave their permission, the staff would have left medications in the room, including narcotics. The residents had to be assessed as appropriate to have medications left in the room and had to be cognitively intact. They were not required to watch the resident's take their medications.<br><br>During an interview, on 9/22/22 at 2:21 p.m., the DON indicated supervision could be considered staff set up of medications. Resident 314 had not given the staff any problems with taking medications as far as she knew, however she was not sure how they would have known if the residents took their medications if the staff did not go back and check. The staff had not gone back to check and see if residents actually took their medications that she was aware of.<br>2. During an observation of Resident 314's room, on 9/23/22 at 9:40 a.m., a medication cup, filled with multiple pills and tablets, was observed on a folding tray table next to the resident's recliner. Resident 314 was seated in the recliner. Resident 314 indicated, she usually took the medications when she came back from breakfast in the dining room, but today she had forgotten to take the medications and laid down in bed for a nap. Resident 314 indicated she was unsure what medications were in the medication cup and the resident counted the medications from the medication cup and indicated there were 21 pills in the cup. Resident 314 indicated the medications were due at 9 a.m. daily. She received medications at 9 a.m., 11 a.m. and a third dose of medicines at bedtime. Resident 314 indicated the facility managed her medications. She indicated she could | | | |

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| | | A. BUILDING 00<br>B. WING | 09/23/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SILVER BIRCH OF TERRE HAUTE | 650 LAFAYETTE AVENUE<br>TERRE HAUTE, IN 47807 |

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| | not manage her own medicines because she would "mess them up."<br><br>Resident 314's record was reviewed on 9/23/22 at 11:15 a.m. The resident was admitted to the facility on 1/11/22 with diagnoses included, but were not limited to, gout (type of inflammatory arthritis that causes pain and swelling in the joints), hypertension (high blood pressure), a-fib (atrial fibrillation - irregular heart rhythm), gastro-esophageal reflux disease (GERD-digestive disease in which stomach acid or bile irritates the food pipe lining), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), anemia (condition in which the blood doesn't have enough healthy red blood cells), neuropathy (Weakness, numbness, and pain from nerve damage, usually in the hands and feet), overactive bladder (a problem with bladder function that causes a frequent and sudden urge to urinate that may be difficult to control), asthma (respiratory condition marked by spasms in the lungs), restless leg syndrome (condition characterized by a nearly irresistible urge to move the legs), incontinence (loss of bladder control, varying from a slight loss of urine after sneezing, coughing, or laughing to complete inability to control urination).<br><br>A Resident Service Plan Level of Service Assessment/Evaluation, dated 6/30/22, indicated Resident 314 required round the clock need for caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect. Resident 314 required a medication service plan with desired outcome of resident will be supported to take all medications safely and as ordered, with interventions included, but not limited to, required daily supervision of medication, and required nurse | | | |

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| | delegation of medications to an aide.<br><br>A medications care plan, initiated on 1/11/22 and revised on 7/19/22, indicated Resident 314 required interventions of daily supervision of medications and required nurse delegation of medications to an aide with the desired outcome of the resident will be supported to take all medications safely and as ordered.<br><br>Active September 2022 physician's orders for Resident 314 included but were not limited to, the following medications scheduled to be administered in the morning:<br><br>Allopurinol Tablet 100 milligrams (mg) - give one tablet by mouth in the morning related to chronic gout.<br><br>Amlodipine Besylate tablet 10 mg - give 1 tablet by mouth daily for hypertension.<br><br>Apixaban tablet 5 mg - give one tablet by mouth two times a day.<br><br>Aspirin low dose tablet chewable 81 mg - give 81 mg by mouth in the morning related to hypertension.<br><br>Dexlansoprazole capsule delayed release 60 mg - give 1 capsule by mouth in the morning related to GERD.<br><br>Duloxetine HCI capsule delayed release particles (drug used to treat depression and neuropathy) 30 mg - give 1 capsule by mouth in the morning related to major depressive disorder.<br><br>Ferrous gluconate tablet 324 mg (iron pill) - give 1 tablet by mouth two times a day related to anemia. | | | |

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| | Furosemide tablet 40 mg - give 40 mg by mouth two times a day related to hypertension.<br><br>Gabapentin tablet 600 mg - give 600 mg by mouth two times a day related to neuropathy.<br><br>Hydralazine HCI tablet 25 mg - give 25 mg by mouth three times a day for hypertension.<br><br>Isosorbide Mononitrate ER (Extended Release) 24-hour tablet 60 mg - give 60 mg by mouth in the morning related to hypertension.<br><br>Metoprolol Tartrate tablet 25 mg - give 3 tablets by mouth two times a day for hypertension.<br><br>Mirabegron ER tablet 24-hour tablet 50 mg - give 50 mg by mouth in the morning related to overactive bladder.<br><br>Montelukast sodium tablet 10 mg - give 10 mg by mouth in the morning for asthma.<br><br>Potassium chloride ER capsule 10 mEq (milliequivalent) - give 3 capsules by mouth two times a day related to hypertension.<br><br>Pramipexole Dihydrochloride tablet 0.5 mg - give 1 tablet by mouth two times a day for restless leg syndrome.<br><br>Vesicare tablet (solifenacin succinate) 5 mg - give 1 tablet by mouth in the morning for incontinence.<br><br>During an interview, on 9/22/22 at 11:24 a.m., the Director of Health and Wellness indicated if a resident was alert and oriented and gave their permission, the staff would have left medications in the room, including narcotics. The residents had to be assessed as appropriate to have | | | |

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| | medications left in the room and had to be cognitively intact. They were not required to watch the resident's take their medications.<br><br>During an interview, on 9/22/22 at 2:21 p.m., the Director of Health and Wellness indicated supervision could be considered staff set up of medications. Resident 314 had not given the staff any problems with taking medications as far as she knew, however she was not sure how they would have known if the residents took their medications if the staff did not go back and check. The staff had not gone back to check and see if residents actually took their medications that she was aware of.<br><br>On 9/22/22 at 11:45 a.m., the Director of Health and Wellness provided and identified a document as a current facility policy, titled "Medication Administration Program Policy," dated 3/24/21. The policy indicated, "...Policy: Our community will provide medication assistance to residents who request assistance. This service is indicated on the Resident Service Plan and will be in compliance with the state's administrative rules and regulations and orders from the physician...Procedure: ...3. Residents receiving medication assistance will have: ...b. Documentation of the medication name, dose, time taken by resident...c. Documentation of refusals or inability to take medication according to the prescription...The community Executive Director and/Director of Health and Wellness will ensure adequate professional oversight of the medication administration program. The elements of an approved medication administration system are as follows: ...1. Each resident is assessed for ability to manage their medications including over-the-counter medications, injectables, and nutritional supplements...2. Written policies | | | |

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| | related to medication assistance and administration are followed by licensed nurses and Qualified Medication Aides (QMAs), within their scope of practice...5. Documentation in the medication record is complete and accurate...a. Resident receives medications as prescribed...." | | | |