STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	C 03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 65	F 428		

but did not document anything about it. Z1 seemed distracted and was not paying attention when she told him. When asked if not getting his medications contributed to R2 going to the hospital, Z3 stated it "didn't help".

Z1, Physician for R2, stated on 3/2/11 at 10:00 AM by phone that he was not aware that R2 was not receiving his medications as prescribed. Z1 stated the facility and Z3, Nurse Practitioner, had not informed him the facility had not given R2 his medications. Z1 stated he didn't know what to say and asked why R2 was not receiving his medications. Z1 stated the pharmacy should have sent the medications. The facility should have helped the resident and provided R2 with his medications. Z1 stated it was inappropriate for the facility not to inform him that R2 was not receiving the medications. Z1 stated "Of course" that the effects of R2 not receiving his medications contributed to his hospitalization. When asked if Z1 considered this neglect he stated "yes" and that R2 "should have gotten the meds".

R2 was hospitalized from 2/21/11 until 2/26/11. The hospital history and physical dated 2/21/11 documented "acute decompensated systolic congestive heart failure" with the "BNP (Brain Natriuretic peptide) 669" and "early signs of cellulitis in toes of both feet" as the assessment. Lab results dated 2/21/11 noted "heavy growth" of Methicillin Resistant Staph Aureus (MRSA) of the right foot. There is no documentation regarding R2 not receiving the medication at the facility.

R2 was readmitted to the hospital on 3/2/11 until 3/4/11. The history and physical dated 3/2/11 noted the chief complaint was "shortness of breath". The report noted R2 was "found to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	C 03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 66 have acute on chronic systolic congestive heart failure exacerbation and was admitted to the intermediate intensive care unit". It was noted that R2 had a history of severe cardiomyopathy and recurrent aspiration of food. R2 was readmitted to the facility on 3/4/11 on hospice and expired on 3/7/11.	F 428		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1210b)3) 300.1610a)1) 300.1620a) 300.1630d) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirments for Nursing and Personal Care a) The facility must provide the necessary care	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	C 03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	**6955 STATE ROUTE 162 MARYVILLE, IL 62062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 67 and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven days a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1610 Medication Policies and Procedures a)1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Section 300.1620 Compliance with Licensed Prescribers orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	C 03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 68 prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calender days, in accordance with Section 300.1810. All such orders shall have the handwitten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as orded by the licensed prescriber and at the designated time. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber ' s medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation and a notation made in the residents record. e) Medication errors and drug reactions shall be immediately reported to the resident ' s physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and the dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident ' s clinical record, and the error or reaction shall also be described in an incident report. Section 300.3240 a) Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These REQUIREMENTS are not met as evidenced by:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	C 03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 69	F9999		

Based on interview and record review it was determined that the facility failed to ensure that 1 (R2) of 3 residents reviewed were free of significant medication errors. This failure resulted in R2 experiencing signs/symptoms of congestive heart failure, such as shortness of breath, edema and cellulitis, for days before being hospitalized with an exacerbation of congestive heart failure. R2 was hospitalized twice and admitted to hospice services on 3/4/11. R2 expired on 3/7/11. In addition, the facility failed to administer intravenous antibiotics to 1 (R1) of 2 residents on sample reviewed for medication of 5 sampled residents

1. R2 was admitted to the facility on 7/15/10 with diagnoses, in part, of congestive heart failure, Parkinson's disease, cerebral vascular accident, hypertension, and atrial fibrillation. R2 was assessed on the 1/11/11 Minimum Data Set as able to make himself understood in his ability to express his ideas and wants and having clear comprehension in his ability to understand others.

According to the "Medications Flowsheet" for January and February, 2011, R2 had physician orders for the following medications (meds): Allopurinol for Gout-200 milligrams (mg) daily, Lasix for congestive heart failure-60 mg daily, Klor-Con for Hypokalemia-20 meq (milliequivalents) daily, Lansoprazole for Esophageal Reflux-30 mg daily, Lisinopril for Hypertension-20 mg daily, Synthroid for Hypothyroidism-75 microgram (mcg) daily, Vitamin D for Vitamin D Deficiency-50, 000 units weekly, Levodopa for Parkinson's Disease-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	C 03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 70	F9999		

25-100 mg 1/2 tablet twice a day, Coreg for Hypertension-25 mg twice a day, Lacri-lube for eye disorder twice a day, Niacin for Eye disorder-250 mg twice a day, and Isosorbide Dinitrate for Hypertension- 10 mg three times per day.

The "Medications Flowsheet" documented R2 did not receive the ordered 60 mg of Lasix from 1/29/11 until 2/15/11, Lisinopril from 1/1/11 until 2/15/11, Coreg from 1/21/11 until 2/15/11, Isosorbide Dinitrate 2/1/11 until 2/15/11, Levodopa from 2/2/11 until 2/15/11 and lacri-lube from 1/26/11 until 2/15/11. The flowsheet shows R2 did not receive Allopurinol, Klor-Con, Lansoprazole, and Synthroid as ordered by the physician from 1/1/11 through 2/14/11.

E2, Director of Nursing, stated on 2/28/11 at 3:30 PM, that the pharmacy stopped sending all medications for R2 the first part of January due to payment issues. R2 received the medication until it ran out and then the medicine was not refilled. E2 confirmed that she had not contacted R2's physician regarding the medications.

E1, Administrator, confirmed the information provided by E2 on 2/28/11. E1 stated she was not aware until last week that R2 was not getting his medications and pharmacy should have notified her. E1 stated staff should have ordered the medication.

Z2, Registered Pharmacist, stated on 3/2/11 at 9:30 AM, that he was not aware R2 had not been receiving his medications until 3/1/11. When asked whether R2 not receiving his medications was a problem for R2, Z2 stated R2 was on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	C 03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 71	F9999		

medications for a reason. The Lisinopril and Lasix were the medications that could cause R2 the worst problems if he did not get the medications. Z2 stated he was not sure if being off the medications caused the congestive heart failure exacerbation but it "didn't help."

On 2/21/11 at 9:15 AM the notes states R2 continued to have 3 plus pitting edema with bilateral lower extremities very painful and red. R2 requested to go to the hospital. The hospital history and physical dated 2/21/11 documented as the "Chief Complaint" "Increased edema in bilateral lower extremities. The exact duration for how long it's been going on is not known." The assessment documented "acute decompensated systolic congestive heart failure " with the "BNP (Brain Natriuretic peptide) 669" and "early signs of cellulitis in toes of both feet."

Z1, Physician for R2, stated on 3/2/11 at 10:00 AM by phone that he was not aware that R2 was not receiving his medications as prescribed. Z1 stated the facility and Z3, Nurse Practitioner, had not informed him the facility had not given R2 his medications. Z1 stated he did not know what to say and asked why R2 was not receiving his medications. Z1 stated the pharmacy should have sent the medications. The facility should have helped the resident and provided R2 with his medications. Z1 stated it was inappropriate for the facility not to inform him that R2 was not receiving the medications. Z1 stated "Of course" that the effects of R2 not receiving his medications contributed to his hospitalization. When asked if Z1 considered this neglect he stated "yes" and that R2 "should have gotten the meds".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	C 03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 72 On 3/2/11, R2 was readmitted to the hospital with diagnoses of pneumonia, congestive heart failure, and dyspnea. The history and physical dated 3/2/11 noted the chief complaint was "shortness of breath." The report noted R2 was "found to have acute or chronic systolic congestive heart failure exacerbation and was admitted to the intermediate intensive care unit." The "Discharge Summary" dated 3/4/11 noted "the patient's sister stated that this has been a gradual decline over the last few months... " The "Discharge Summary" noted R2 was medically stable on discharge with his heart failure exacerbation controlled. Lasix was increased from 60 mg to 80 mg. R2 was readmitted to the facility on 3/4/11 on hospice. On 3/7/11 at 2:34 AM the nurses notes states R2 was found expired at 1:30 AM. The State "Certificate of Death" dated 3/8/11 and signed by Z7 noted the "Immediate Cause" of death as "Congestive Heart Failure." 2. R1 was admitted to the facility on 12/4/10 with diagnoses, in part, of debility, intractable back pain, hypertension, and depression. On 12/2/10 R1 was admitted to the hospital for increased lethargy and confusion according to the hospital history and physical. R1 was found to have a urinary tract infection and pneumonia. R1 was discharged to the facility on 12/4/10 at 6:00 PM with orders for Intravenous (IV) Antibiotics of Zosyn in dextrose piggyback, 3.375 grams/50 milliliters every 6 hours.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	C 03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 73	F9999		

E2, Director of Nursing, stated on 3/2/11 that there were issues with R1's IV's. E2 stated R1 returned to the facility on the weekend with orders for IV antibiotics and there was no registered nurse at the facility to administer the IV. The physician was called and told him they could not do the IV and asked for an oral medication the physician refused. The physician was called again to discontinue the IV order or send R1 back to the hospital but the physician refused. E2 confirmed that the physician did not discontinue the IV order. E2 stated that the physician was called off hours and was told the "IV (was) not happening" and he was angry. The facility called Hospice and requested an order for oral antibiotics. The next day hospice came in and put R1 on oral antibiotics. A Discharge Summary from Z6, physician, dated 12/04/10, documents R1 was discharged to the facility with an intravenous (IV) access port on 12/04/10, after hospital treatment for a urinary tract infection and pneumonia. Z6's admission orders to the facility on 12/04/10 include an order for Ondansetron Hydrochloride Solution, 4 Milligrams (mg)/2 milliliter (ml), amount of 2 mg, IV PRN (as needed), for nausea and vomiting. Also ordered, the antibiotic Zosyn in dextrose piggyback; 3.375 grams/50 ml IV every 6 hours for the continued treatment of sepsis.

On 3/07/11, at 2:50 PM, E2, Director of Nursing, (DON) stated, "We were not prepared for the IV Zosyn ordered to continue for (R1) on 12/04/10, when she returned from the hospital. She (R1) had an IV access port. No one was available at that time to start an IV." E2 confirmed R1 never received the IV Zosyn because the hospice nurse came on 12/05/10, and an order was obtained for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	C 03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 74	F9999		

the oral antibiotic, Levaquin.

The Nurses Note, dated 12/04/10, confirms a physician was notified and twice refused to discontinue the IV Zosyn as ordered. The Nurses Note, dated 12/04/10, at 6:00 PM, reads, "Spoke with DON once again and discussed what MD (medical doctor) had said. Decided we would wait till ABT (antibiotic) came from pharmacy and after hospice came in AM (morning) and see what hospice wanted to do."

The Medication Administration Record (MAR), for 12/2010 documents both IV medications of Zosyn and Ondansetron Hydrochloride were never administered and were discontinued for R1.

On 3/08/10, at 1:50 PM, Z1, Physician reported Z6, Physician discharged R1 from the hospital on 12/04/10 with the order for IV Zosyn. Z1 reported he would not have discontinued the IV Zosyn and the facility should be capable of administering an IV antibiotic. Z1 reported he has had problems with his residents at the facility receiving medications as ordered. Z1 reported R1 should have received the IV Zosyn, and he would never refuse to send any resident to the hospital.

On 3/08/10, at 2:45 PM, Z6, Physician reported he does not remember the specifics of R1's discharge on 12/04/10. Z1 reported if he discharged a resident to a nursing home with an IV antibiotic he would expect the hospital and the receiving facility to coordinate the discharge care so R1 could receive the IV medications as ordered. Z1 stated, "The nursing home is required to be prepared for IV therapy for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	C 03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	**6955 STATE ROUTE 162 MARYVILLE, IL 62062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 75 resident." Z1 confirmed he would not have discontinued the IV Zosyn, and was not aware R1 did not receive it. Z1 reported he would never send her back to the hospital to just receive IV medication. Z1 reported the facility's DON should have been available to start the IV. The facility's policy and procedure, entitled, "Administration of an Intermittent Infusion," documents a physician's order is required for an intermittent infusion, and licensed nurses are expected to follow infection control and safety compliance procedures. The facility's policy entitled, 'Medication Administration', reads, "Objective; 1. To provide the resident with those medications deemed necessary by the physician to improve and/or stabilize specified diagnosis of the resident." (A)	F9999		