STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215067	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SALISBURY REHABILITATION AND NURSING CENTER	**200 CIVIC AVENUE SALISBURY, MD 21804**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Facility Reported Incident, medical record review and staff interviews and observation, it was determined that the facility failed to administer medications in accordance with accepted standards of nursing practice. Licensed Practical Nurse (LPN) #9 administered Resident #3's medication to Resident #2. This was evident for 1 of 5 residents reviewed during this COVID-19 facility focused survey and complaint survey. The findings included: The nursing profession has an accepted standard called the 5 Rights of Medication Administration: Right Dose, Right Route, Right Medication, Right Patient, and Right Time. On 6-22-2020 on the secured Memory Care Unit at 10:00 AM, LPN #9 had taken Resident #2's blood pressure in preparation of administering his/her medications. LPN #9 changed his/her mind and since Resident #3's morning medication included a pain medication decided to give his/her medications before administering Resident #2's. After Resident #3's medications, [MEDICATION NAME] 7.5 mg, Megase 20 mg and [MEDICATION NAME] 40mg delayed release had been placed in the medication cup 2 other residents started arguing. To prevent the argument from escalating LPN #9 locked Resident #3's medication in the medication cart and went and separated the other two residents. Once back at the cart LPN #9 saw Resident #2 and unlocked the cart and obtained the cup with Resident #3's medication and gave it to Resident #2. LPN #9 immediately realized the mistake of giving Resident #2 Resident #3's medication. The facility Nurse Practitioner was notified and immediately assessed Resident #2, facility and family were, also, notified. Resident #2 had no change in vital signs throughout the day and remained at his/her same usual level of alertness. LPN #9 failed to follow the basic professional standard of the 5 rights of medication administration. On 7-1-2020 the Director of Nursing confirmed that LPN #9 did not follow the standard of practice for medication administration.

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