STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018368	A. BUILDING: _____ B. WING _____	R-C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING EAST	968 E MADISON STREET WATERLOO, WI 53594

(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) COMPLETE DATE
{N 000}	Initial Comments On 05/15/2024, with information obtained through 05/16/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Victory Vision Community Living East, a community-based residential facility (CBRF) located in Waterloo, WI. As a result of the survey, 3 deficiencies were identified. All 3 deficiencies are repeat deficiencies from Statement of Deficiency (SOD) N7X611, dated 10/27/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 5	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 2 received his/her insulin in the dosages prescribed by his/her practitioner. From 04/01/2024 - 05/15/2024, Resident 2 received the incorrect insulin dosage on 20 occasions.	{N 352}		

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

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{N 352}	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) N7X611, dated 10/27/2023. Findings include: On 05/15/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 03/22/2021 with diagnoses including type I diabetes mellitus. Surveyor reviewed Resident 2's prescriptions, which included the following: - (Breakfast) Lyumjev KwikPen 100 units/mL injection with a start date of 03/08/2024 and instructions to, "Inject 1 unit for 7 grams of carbs before breakfast plus sliding scale..." - (Lunch) Lyumjev KwikPen 100 units/mL injection with a start date of 03/08/2024 and instructions to, "Inject 1 unit for 8 grams of carbs before lunch plus sliding scale..." - (Dinner) Lyumjev KwikPen 100 units/mL injection with a start date of 03/07/2024 and instructions to, "Inject 1 unit for 20 grams of carbs before dinner plus sliding scale..." - (Bedtime) Lyumjev KwikPen 100 units/mL injection with a start date of 03/07/2024 and instructions of, "Bedtime sliding scale: 0-150 = +0, 151-200 = +1, 201-250= +2, 251-300 = +3, 301-350 = +4, 351-400 = +5" The sliding scale for the above 3 mealtime insulin orders was as follows: "0-150 = +0, 151-200 = +1, 201-250 = +2, 251-300 = +3, 301 - 350 = +4, 351 - 400 = +5 Max = 50 units/day..." Another order with a start date of 04/05/2024 documented, "If blood sugar <120, hold carb count insulin dosing & recheck blood sugar in 1 hour."	{N 352}		

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{N 352}	Continued From page 2 Surveyor reviewed Resident 2's medication administration records (MARs) from 04/01/2024 through 05/15/2024 and observed the following 20 discrepancies: - 04/03/2024 (dinner): Blood sugar documented as 199, with 24 grams of garbs consumed (within parameters for 1 unit of insulin-to-carb ratio (ICR) insulin), 4 units of ICR insulin documented as administered - 04/04/2024 (dinner): Blood sugar documented as 130, with 30 grams of garbs consumed (within parameters for 2 units of ICR insulin), 4 units of ICR insulin documented as administered - 04/06/2024 (breakfast): Blood sugar documented as 102, with 48 grams of garbs consumed (within holding parameters per the above order), 7 units of ICR insulin documented as administered - 04/06/2024 (dinner): Blood sugar documented as 227, with 35 grams of garbs consumed (within parameters for 2 units of ICR insulin), 7 units of ICR insulin documented as administered - 04/06/2024 (bedtime): Blood sugar documented as 237 (within parameters for 2 units of sliding scale insulin), 4 units of sliding scale insulin documented as administered - 04/07/2024 (dinner): Blood sugar documented as 262, with 70 grams of garbs consumed (within parameters for 4 units of ICR insulin), 10 units of ICR insulin documented as administered - 04/08/2024 (dinner): Blood sugar documented as 82, with 50 grams of garbs consumed (within holding parameters per the above order), 4 units	{N 352}		

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{N 352}	Continued From page 3 of ICR insulin documented as administered - 04/10/2024 (breakfast): Blood sugar documented as 85, with 25 grams of garbs consumed (within holding parameters per the above order), 3 units of ICR insulin documented as administered - 04/12/2024 (lunch): Blood sugar documented as 375, with 109 grams of garbs consumed (within parameters for 14 units of ICR insulin and 5 units of sliding scale insulin), 13 units of ICR insulin and 4 units of sliding scale insulin documented as administered - 04/13/2024 (dinner): Blood sugar documented as 400, with 0 grams of carbs consumed (within parameters for 5 units of sliding scale insulin), 7 units of sliding scale insulin documented as administered - 04/13/2024 (bedtime): Blood sugar documented as 400 (within parameters for 5 units of sliding scale insulin), 7 units of sliding scale insulin documented as administered - 04/21/2024 (lunch): Blood sugar documented as 250, with 65 grams of garbs consumed (within parameters for 2 units of sliding scale insulin), 3 units of sliding scale insulin documented as administered - 04/28/2024 (dinner): Blood sugar documented as 186, with 65 grams of garbs consumed (within parameters for 3 units of ICR insulin), 4 units of ICR insulin documented as administered - 05/04/2024 (lunch): Blood sugar documented as 101, with 52 grams of garbs consumed (within holding parameters per the above order), 7 units	{N 352}		

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{N 352}	Continued From page 4 of ICR insulin documented as administered - 05/06/2024 (lunch): Blood sugar documented as 111, with 21 grams of garbs consumed (within holding parameters per the above order), 3 units of ICR insulin documented as administered - 05/11/2024 (breakfast): Blood sugar documented as 118, with 50 grams of garbs consumed (within holding parameters per the above order), 7 units of ICR insulin documented as administered - 05/11/2024 (lunch): Blood sugar documented as 73, with 48 grams of garbs consumed (within holding parameters per the above order), 6 units of ICR insulin documented as administered - 05/11/2024 (dinner): Blood sugar documented as 105, with 48 grams of garbs consumed (within holding parameters per the above order), 2 units of ICR insulin documented as administered - 05/12/2024 (dinner): Blood sugar documented as 255, with 65 grams of garbs consumed (within parameters for 3 units of ICR insulin and 3 units of sliding scale insulin), 8 units of ICR insulin and 2 units of sliding scale insulin documented as administered - 05/13/2024 (breakfast): Blood sugar documented as 300 (within parameters for 3 units of sliding scale insulin), 5 units of sliding scale insulin documented as administered At approximately 2:40 p.m., Surveyor interviewed Lead Caregiver C and Manager I. Manager I reported that s/he would discuss the errors during the next manager meeting and follow up with further discussions and education with staff.	{N 352}		

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{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that Resident 2's individual service plan (ISP) was updated to reflect his/her change in needs related to management of high blood sugars, hospice services, known catheter-related behaviors, his/her carb consumption limitations, and right lower extremity residual limb bathing precautions. This is a repeat deficiency. See Statement of Deficiency (SOD) N7X611, dated 10/27/2023. Findings include: On 05/15/2024, at approximately 10:35 a.m., Surveyor observed Manager I, who was working the floor as a caregiver. Manager I was observed administering a medication to Resident 2, which s/he reported was Zofran due to Resident 2 throwing up all morning. When asked more about	{N 389}		

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Resident 2's condition, Manager I reported that Resident 2 had high blood sugar earlier that morning with a value of over 500. Manager I reported that s/he called Resident 2's hospice team for further guidance, who instructed him/her to administer 5 units of insulin and monitor by testing his/her blood sugar.

At approximately 10:45 a.m., Manager I was observed on the phone discussing Resident 2's blood sugar. Manager I reported to Surveyor afterwards that the phone call was with Resident 2's hospice agency and s/he was relaying that Resident 2's last tested blood sugar value was 579. Manager I reported that the person on the phone told him/her that Resident 2's hospice nurse would call him/her back with further guidance.

On 05/15/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 03/22/2021 with diagnoses including type I diabetes mellitus. Surveyor reviewed Resident 2's current ISP, last signed as reviewed on 02/05/2024. Surveyor observed the following related to Resident 2's needs and services:

- Under the "Bathing" heading: "...Had surgery on Right Foot, removal of two toes and infection from bone, needs leg and foot wrapped with bag before getting into shower, needs assistance with washing back when needed, and keeping leg dry. after done with shower needs assistance with some drying of body and removing cover from Right Leg..."

- Under the "Toileting" heading: "...Have catheter bag drained and then documented to avoid infection and urine retention...Document color and output, any change in condition...Requires

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{N 389}	Continued From page 7	{N 389}		

staff monitoring, verbal prompts, and cues with toileting needs...AS OF 3/21/22 HAS AN [SUPRAPUBIC] CATHETER, STAFF TO DOCUMENT OUTPUT AND IF THERE IS ANY SIGNS OF INFECTION OR NO DRAINAGE FROM CATHETER." Surveyor did not observe any other information regarding his/her catheter in his/her ISP.

- Under the "Meal Preparation" heading: "Requires assistance with food preparation needs...Carb count not to go over 80 grams of carbs per meal...:

- Under the "Diabetes Management" heading: "Requires blood sugars to be taken 4x's a day (before meals and at bed time.) More if High or low blood sugars...Staff to document and report highs and lows what was done to correct...Active Diabetic with high blood sugars, report highs/lows to doctor..." Surveyor did not observe specific parameters, such as specific blood sugar values, documented in this direction.

- Under the "Recurring Illness" heading: "When [Resident 2] is throwing up with a High blood sugar, [s/he] needs to be sent out per endo[crinologist]."

There was no information in Resident 2's ISP regarding him/her receiving hospice services.

Surveyor observed Resident 2's medication administration records (MARs) from 04/01/2024 - 05/15/2024, where staff documented Resident 2's carb consumption. Surveyor observed the following 11 occasions that Resident 2's carb consumption was over 80 grams, contrary to what was directed from his/her ISP:

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{N 389}	Continued From page 8 - 04/05/2024 (dinner): 81 carbs documented as consumed - 04/08/2024 (lunch): 90 carbs documented as consumed - 04/10/2024 (dinner): 131 carbs documented as consumed - 04/11/2024 (dinner): 83 carbs documented as consumed - 04/12/2024 (lunch): 109 carbs documented as consumed - 04/25/2024 (breakfast): 82 carbs documented as consumed - 04/25/2024 (lunch): 81 carbs documented as consumed - 05/07/2024 (breakfast): 82 carbs documented as consumed - 05/07/2024 (lunch): 146 carbs documented as consumed - 05/09/2024 (dinner): 89 carbs documented as consumed - 05/10/2024 (lunch): 94 carbs documented as consumed At approximately 1:05 p.m., Surveyor interviewed Caregiver F about Resident 2's carb restriction. Caregiver F reported s/he wasn't sure about a restriction and would have to ask his/her supervisor. Surveyor then heard Caregiver F on the phone asking about Resident 2's carb consumption. After his/her phone conversation, Caregiver F reported to Surveyor that staff were to limit Resident 2's carb consumption to under 100 grams per meal but this was not a firm restriction. While reviewing Resident 2's record, at approximately 1:11 p.m., Surveyor observed Resident 2 seated in his/her manual wheelchair at the kitchen bar getting ready to eat lunch. Resident 2's catheter bag was resting in his lap	{N 389}		

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with the tubing approximately near his/her waist level. Caregiver F was observed testing his/her blood sugar, which s/he reported was 594. Caregiver F confirmed s/he was still waiting to hear back from hospice for further guidance. A few minutes after this, Resident 2 was observed eating lunch. While s/he was eating, Lead Caregiver C was observed talking with him/her. Resident 2's catheter bag was observed on his/her lap throughout the meal. While seated, Surveyor observed Resident 2's right lower extremity. Resident 2 was observed with a below knee amputation, with the skin well healed around the residual limb. There were no open areas observed at Resident 2's residual limb. At approximately 1:38 p.m., Surveyor observed Manager I discuss Resident 2's catheter bag with Lead Caregiver C. Manager I reported to Surveyor that s/he tried talking to Resident 2 about it earlier and Resident 2 had just moved him/her away. Manager I reported that staff frequently attempted to correct Resident 2's catheter bag positioning but s/he typically refused the assistance.

At approximately 2:08 p.m., Surveyor interviewed Caregiver F and Manager I. Both confirmed that Resident 2 received hospice services, and that s/he typically had a nurse, Nurse K, visit about once per week. Caregiver F reported that during the visits, Nurse K took Resident 2's vitals and sometimes changed out or flushed his/her catheter bag. When asked who was primarily responsible for changing out Resident 2's catheter bag, Caregiver F replied that both the provider's staff and Nurse K do this task. Regarding Resident 2's medical provider diabetes management, both Caregiver F and Manager I confirmed that hospice, not the endocrinology clinic, was who staff contacted for management

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{N 389}	Continued From page 10	{N 389}		

of Resident 2's high blood sugars. When asked what the upper parameter value was for when staff were to call hospice, Caregiver F replied that s/he was unsure about a specific upper parameter value. Manager I reported that s/he thought it was supposed to be when blood sugars were over 400.

Upon reviewing Resident 2's record again - in his/her MARs, where staff documented blood sugars and on occasion documented guidance received from hospice, and his/her observation notes - Surveyor observed the following 9 occasions from 04/01/2024 - 05/15/2024 that Resident 2's blood sugar was over 400 but there was no evidence of staff having notified his/her hospice provider, having completed any other monitoring of Resident 2, or having utilized any other intervention for managing the high blood sugar:

- 04/07/2024 (9:01 a.m.): Blood sugar of 571 (next blood sugar recorded approximately 3.75 hours later at 12:42 p.m.)
- 04/09/2024 (8:35 a.m.): Blood sugar of 500 (next blood sugar recorded approximately 4.5 hours later at 12:57 p.m.)
- 04/09/2024 (5:18 p.m.): Blood sugar of 460 (next blood sugar recorded approximately 2.75 hours later at 8:02 p.m.)
- 04/12/2024 (8:31 a.m.): Blood sugar of 540 (next blood recorded approximately 4 hours later at 12:28 p.m.)
- 04/25/2024 (8:25 a.m.): Blood sugar of 471 (next blood sugar recorded approximately 4 hours later at 12:24 p.m.)
- 04/30/2024 (8:40 a.m.): Blood sugar of 423 (next blood sugar recorded approximately 4 hours later at 12:37 p.m.)
- 05/02/2024 (9:00 a.m.): Blood sugar of 465

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{N 389}	Continued From page 11 (next blood sugar recorded approximately 3.5 hours later at 12:34 p.m., as below) - 05/02/2024 (12:34 p.m.): Blood sugar of 425 (next blood sugar recorded approximately 5 hours later at 5:28 p.m.) - 05/08/2024 (9:12 a.m.): Blood sugar of 429 (next blood sugar recorded approximately 3.5 hours later at 12:43 p.m.) At approximately 2:40 p.m., Surveyor interviewed Lead Caregiver C and Manager I. Regarding the bathing precautions with Resident 2's right residual limb directed from his/her ISP, both reported that the precautions were outdated and that staff were not currently having to wrap Resident 2's limb or avoid it from getting wet. Regarding the direction in his/her ISP for staff to send Resident 2 out via emergency medical services when s/he had a high blood sugar and was throwing up, both acknowledged Surveyor's observation that this seemed to be outdated information based on that not having occurred earlier that morning when Resident 2 was experiencing vomiting and high blood sugars. Both reported they did not think Resident 2's endocrinologist was involved with Resident 2's care anymore and that staff have primarily worked through his/her hospice team for any medical concerns. Regarding the management of Resident 2's high blood sugars, Manager I acknowledged Surveyor's concern that there was not specific details with regards to the management of Resident 2's high blood sugars - such as a defined specific parameter for which staff were guided to contact hospice or conduct further monitoring. Lead Caregiver C reported that s/he would work on updating Resident 2's ISP, and both Lead Caregiver C and Manager I reported that they would follow up with Resident 2's hospice agency for more specific guidance.	{N 389}		

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{N 389}	Continued From page 12 On 05/16/2024, at approximately 12:00 p.m., Surveyor interviewed Nurse K. Nurse K reported that Resident 2 was admitted to hospice on 02/26/2024. Nurse K reported that s/he was aware of Resident 2's behaviors of refusing appropriate placement of his/her catheter bag. Nurse K reported that staff often correct him/her or attempt to place it appropriately and educate him/her but that Resident 2 was stubborn and moved the bag him/herself. Nurse K reported that since initiating hospice, Resident 2 was no longer seeing his/her endocrinologist. Nurse K reported that s/he was unaware of Resident 2 having any sort of carb consumption limits since his/her transition to hospice. Nurse K reported that Resident 2 may have had an old limit from his/her endocrinologist, but this would have ended once Resident 2 transitioned to hospice.	{N 389}		
{N 432}	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not provide medication	{N 432}		

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{N 432}	Continued From page 13	{N 432}		

administration services appropriate to Resident 1's needs.

An approximate 30 day supply of Resident 1's systane eye drops and an approximate 50 day supply of his/her polymyxin eye drops were most recently dispensed on 11/23/2023 and 11/20/2023, respectively. Both drops were prescribed for multiple administrations daily. When observed on 05/16/2024 by Surveyor, approximately 6 months after the dates the drops were last dispensed, Resident 1's systane bottle appeared to be near completely full and his/her polymyxin bottle appeared to be approximately halfway full. Interview with Caregiver F revealed that Resident 1's systane eye drops were administered but not his/her polymyxin eye drops, despite both being scheduled medications. Review of Resident 1's medication administration records (MARs) revealed that staff incorrectly entered Resident 1's systane eye drops as an as needed (PRN) medication on 11/21/2023, and documented no administrations of it after this date. Review of Resident 1's MARs also revealed that staff signed off on approximately 174.5 days of administering Resident 1's polymyxin drops since 11/20/2023, despite the bottle only containing approximately 50 days worth of doses.

This is a repeat deficiency. See Statement of Deficiency (SOD) N7X611, dated 10/27/2023.

Findings include:

On 05/15/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 12/16/2020 with diagnoses including profound intellectual disabilities. Resident 1's prescriptions included the following:

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{N 432}	Continued From page 14 - Polymyxin B / trimethoprim ophthalmic solution with an original start date of 07/20/2023 and instructions to, "Instill one drop in left eye four times daily (wait 1 minute between drops & 5 minutes between different drops)." - Systane 0.3/0.4% ophthalmic solution with an original start date of 05/11/2023 and instructions to, "Instill one drop in both eyes 5 times daily (wait 1 minute between drops & 5 minutes between different drops)." At approximately 1:45 p.m., Surveyor observed the medication cart with Caregiver F, and observed the following: - One 10 mL bottle of polymyxin B / trimethoprim ophthalmic solution prescribed to Resident 1. The pharmacy label for the medication identified that the bottle was dispensed on 11/20/2023. The bottle appeared to be approximately half full (Photo 1, Photo 2) - One 15 mL bottle of systane ophthalmic solution prescribed to Resident 1. The pharmacy label for the medication identified that the bottle was dispensed on 11/23/2023. The bottle appeared to be nearly completely full (Photo 3, Photo 4) While observing the medication cart, Surveyor interviewed Caregiver F. Caregiver F confirmed there were no other bottles of eye drops for Resident 1. Caregiver F reported that Resident 1 was not known to refuse his/her eye drops. After reviewing both of the above bottles with Caregiver F, Caregiver F reported that s/he had administered the systane eye drops to Resident 1 but not the polymyxin eye drops. Caregiver F reported s/he was not familiar with the polymyxin eye drops and that s/he thought the polymyxyin	{N 432}		

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{N 432}	Continued From page 15 drops were only administered in relation to an eye infection Resident 1 had approximately 1 month ago. On 05/15/2024, Surveyor continued reviewing Resident 1's record. Surveyor reviewed Resident 1's MARs from 11/01/2023 - 05/15/2024 and observed the following: - In the MAR for November 2023, systane eyedrops were documented as ending as a scheduled medication on 11/21/2023 and starting as a PRN medication that same day. All MARs after this documented the systane eye drops as a PRN medication despite the order instructions continuing to direct staff to administer 1 drop to both eyes 5 times daily. After 11/21/2023, there were no entries documenting that staff administered Resident 1's systane eye drops. - Since 11/21/2023 (the day after Resident 1's polymyxin eye drops were dispensed), staff documented administering Resident 1's polymyxin drops on the following 174.5 days: 1) 11/21/2023 through 11/30/2023: 37 of 40 administrations, or approximately 9 days 2) 12/01/2023 through 12/31/2023: 124 of 124 administrations, or 31 days 3) 01/01/2024 through 01/31/2024: 124 of 124 administrations, or 31 days 4) 02/01/2024 through 02/29/2024: 116 of 116 administrations, or 29 days 5) 03/01/2024 through 03/31/2024: 124 of 124 administrations, or 31 days 6) 04/01/2024 through 04/30/2024: 118 of 120 administrations, or 29.5 days 7) 05/01/2024 through 05/15/2024: 56 of 56 administrations, or 14 days	{N 432}		

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{N 432}	Continued From page 16 At approximately 2:40 p.m., Surveyor interviewed Lead Caregiver C and Manager I. Both reported being unaware of any issues with staff administering Resident 1's eye drops. Lead Caregiver C confirmed with Surveyor the order for Resident 1's systane eye drops as written. Both Lead Caregiver C and Manager I confirmed they did not see anything in the order indicating the systane eye drops were to be administered on a PRN basis instead of scheduled. During the interview, Lead Caregiver C was observed to review the systane eye drops prescription in Resident 1's electronic file. Lead Caregiver C reported s/he could see that someone had documented in the electronic system that the eye drops were a PRN medication, but s/he was not sure why. Both Lead Caregiver C and Manager I acknowledged Surveyor's concern that with the inconsistencies between the MAR documentation, Caregiver F's report of drops administered, and the amounts of medication still in the bottles, there was no way to verify how staff were administering Resident 1's 2 different eye drops. On 05/16/2024, at approximately 11:30 a.m., Surveyor interviewed Assistant Director J, who was also a pharmacy technician with the pharmacy that dispensed Resident 1's medications. Assistant Director J confirmed that 11/23/2023 was the most recent date Resident 1's systane eye drops were dispensed. Assistant Director J confirmed the order for the systane eye drops, as written previously, and confirmed that this was not a PRN medication. Assistant Director J reported that the provider's staff must have accidentally manually entered the systane drops as a PRN medication. Assistant Director J reported that when administered as prescribed, Resident 1's systane eye drop bottle consisted of	{N 432}		

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{N 432}	Continued From page 17 an approximate 30 day supply. Regarding Resident 1's polymyxin eye drops, Assistant Director J confirmed the order as written previously and confirmed that this was not a PRN medication. Assistant Director J confirmed that 11/20/2023 was the most recent date Resident 1's polymyxin eye drops were dispensed. Assistant Director J reported that prior to this, Resident 1's polymyxin drops were dispensed on 07/20/2023 (approximately 4 months prior to the most recent dispense date). Assistant Director J reported that when administered as prescribed, Resident 1's polymyxin eye drop bottle consisted of an approximate 50 day supply. Assistant Director J reported that unless Resident 1 had been out of the facility for extended periods of time, such as for a hospitalization, it didn't seem right that there was still so much leftover solution in the bottle.	{N 432}		