STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145731	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citadel at Saint Benedict	6930 West Touhy Avenue Niles, IL 60714

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 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066 Based on interview and record review the facility failed to monitor and assess for signs of urinary catheter obstruction and monitor urine output for one (R21) of one resident reviewed for urinary tract infections on the sample list of 37. This failure resulted in R21's emergent hospitalization and diagnosis of severe sepsis and acute kidney injury. Findings include: R21 is a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including but not limited to Metabolic Encephalopathy; Alzheimer's Disease; Age related Osteoporosis; Anemia; and Peripheral Vascular Disease. R21's physician order dated 02/01/2024 reads in part, (Urinary) catheter care every shift; Change (Urinary) catheter as needed. R21's care plan reads in part, Problem onset: (R21) has (urinary) catheter to assist in unstageable sacral pressure ulcer. Approaches: Ongoing assessment of color, clarity and character of (R21's) urine; Ongoing assessment of (R21's) for symptoms of urinary [NAME] infection; Change (R21's) catheter tubing/bag per protocol and as needed. On 05/15/24 at 11:04 AM V16 (Licensed Practical Nurse) stated in summary: Urinary catheter care is split between nurses and Certified Nursing Assistants (CNAs). Nurses flush urinary catheter if there is an order. CNAs do catheter perineal care and empty urinary catheter bags and report to the nurse if there are any changes in urine appearance. If a CNA reports to the nurse that there is a sediment or change in urine appearance or output volume, the nurse will call the doctor and obtain flush order unless there is existing order. Nurses are obligated to assess the catheter every shift. I might have worked with R21 on days prior to her hospitalization but I did not notice any changes in the urine output or appearance. We don't document catheter assessments if there are no concerns, we are not obligated to document on routine catheter assessment. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	On 05/15/24 at 11:17 AM V3 (Quality Director/Infection Preventionist) stated in summary: Urinary catheter care is divided between nurses and CNAs. Nurses insert urinary catheter, flush it, and obtain specimen samples. CNAs do perineal care along with catheter care and change the bag if needed. Nurses and CNAs are required to assess urinary catheters every shift (three shifts a day). Urinary catheter assessment is done to prevent infections and to monitor for symptoms of dehydration. Nurse's urinary catheter assessment should consist of urine appearance, signs of occlusion, determination whether catheter is intact and patent, scheduled bag or catheter change, and flushing. CNAs would change urinary bag if catheter went from full bag to a leg bag and opposite, and they are also required to clean the catheter tube. On 04/22/2024, Agency nurse was on duty, and she called me to further assess R21. R21's blood pressure was dropping, and she was unresponsive. I went and called the doctor and said that we will be sending R21 to the hospital. On 05/15/24 at 11:54 AM V17 (Certified Nursing Assistant) stated in summary: Certified Nursing Assistants have to make sure urinary bags are emptied by the end of the shift. I was told to report if I see any blood in the urine, resident experiences pain from the catheter, or if something looks different in general. Facility's expectation for catheter monitoring is every time I provide perineal care. Catheter perineal care should be done at the beginning of each shift, especially, to make sure bag is empty. If a urinary catheter is obstructed the urine will not drain to the bag and that should be reported to the nurse. We are required to document that urinary catheter is present but not that the bag was emptied, or care was provided. On 05/15/24 at 12:32 PM V18 (Certified Nursing Assistant) stated in summary: I took care on R21 on the morning of 04/22/024. I noticed that R21 was out of it, and she didn't look good, so I notified the nurse (V16) on duty. I performed R21 perineal care before earlier that morning, I didn't notice anything different with her catheter, there was no urine or sediment in the tubing and urinary bag was empty. On 05/15/24 at 02:21 PM V16 (LPN) stated in summary: I work on both days before R21 was hospitalized and there was nothing wrong with R21's catheter on 04/20/2024 and 04/21/2024, at least I didn't document anything in the progress note, which means there was nothing unusual. CNAs didn't notify me of anything unusual either. We are not required to document urinary catheter output. If there is no urine output, CNAs usually notify the nurse. Urinary catheter care consists of checking that catheter is intact, and there are no problems with it. Urinary catheter assessment is done quarterly. Nurses and CNAs are both responsible for catheter assessment. There is no daily urinary catheter assessment documentation required by the facility. On 05/15/24 at 03:47 PM V2 (Director of Nursing) stated in summary: Urinary output is not required to be documented; it is something we need to implement. Urinary catheter care is documented in the Treatment Administration Record, and it shows that nurses ensuring that urinary catheter care has been done properly by CNAs. Surveyor pointed out that R21's Treatment Administration Record shows that urinary catheter care was done on two shifts after R21 was transferred to the hospital on 04/22/2024, V2 (DON) stated, I doubt nurses went to the hospital to check on R22's urinary catheter, nurses should be documenting what they truly done. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 05/16/24 at 11:26 AM V27 (Medical Director) stated in summary: Urinary catheter calcification is a buildup of calcium and plaque that occurs in the bladder and can transfer into catheter tubing and urinary bag. I don't know how long it takes for calcification to build up to the point of obstruction. Obstructive uropathy is an obstruction of urine drainage that can cause urinary retention. Obstruction causes urine to be stagnant in the bladder and that's what causes infection, but the time frame to develop infection depends on the resident. Urinary catheter should be flushed at least once a shift, I imagine it is included in the urinary catheter care. It is important to document residents' urinary output to monitor whether urinary catheter is obstructed. Urine output should be documented once a shift. Progress note dated 04/22/2024 at 12:37 PM written by V3 (Quality Director/Infection Preventionist) reads in part, Today, approximately at 11:30 (AM), (R21's) bp (blood pressure) was 87/56 with spo2 (oxygen saturation) at 97%. Intact (urinary) catheter draining dark colored urine. Hospital record dated 04/22/2024 4:42 PM reads in part, HPI (History of present illness): (R21) from nursing home after being found to be unresponsive today, with tachycardia and hypotension. Per (family member) at bedside, states that (R21) was eating appropriately and acting her normal self approximately 1 week ago and is nervous (R21) has developed yet another infection that has led to today symptom. Diagnosis: Severe Sepsis, Dehydration, AKI (Acute Kidney Injury). Assessment: It is clear (urinary) catheter has not been replaced for multiple days and had calcified to the point of obstruction. Obstructive uropathy with subsequent UTI (urinary [NAME] infection) found on physical exam and laboratory findings. R21's (Urinary) catheter care record for February, March and April (1st to 21st) 2024 show that urinary catheter care was done inconsistently. R21's (Urinary) catheter care record for April 22, 2024, shows that urinary care was documented after R21's hospital transfer. Urinary catheter care record appears inaccurate and not well documented . R21's Change (urinary) catheter as needed record shows that R21's urinary catheter was never documented as changed between 02/01/2024 and 04/22/2024. There is no record of R21's urinary catheter output documented between 02/01/2024 and 04/22/2024. There is no record of R21's assessment, change in condition, or vital signs documented in days preceding to 04/22/2024. Last know vital signs set checked on 02/16/2024. The facility policy Procedure: Urinary Catheter Care dated 01/2024 reads in part, Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to the physician or supervisor. It is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Observe for other signs and symptoms of urinary [NAME] infection or urinary retention. Report findings to the physician or supervisor immediately. If the catheter material is contributing to obstruction, notify the physician and change the catheter if instructed to do so.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 45395 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent (%). A medication pass observation on 05/13/2024 revealed 26 medication administration errors out of 31 opportunities, resulting in an 83.87% medication error rate. Findings include: Medication pass observation conducted on 05/13/2024 with V5 and V13 (Agency Registered Nurses) to 3 residents (R6, R7, R33) with the following observations: R7: On 05/13/24 11:28 AM, entered R7's room and observed a small clear plastic medication cup on top of the bedside table that was near the foot of bed which contained nine pills within. When asked whose medications were on the table, R7 stated those are my morning meds. She added that the nurse brought them earlier this morning, but she does not recall her name of nurse or the exact time the pills were left but knows it was before breakfast. R7 then said she knows the nurses are not supposed to leave her medications and she would prefer if the nurse stayed, but they are busy and trust her (R7) enough to take them by herself. When asked what the medications were called, resident stated they were the same ones I take every morning, but I haven't taken them yet. On 05/13/24 at 11:52 AM, observed V5 (Agency Registered Nurse) enter R7's room to administer her noon meds when surveyor observed V5 pick up a plastic med cup which contained the nine pills previously observed on R7's bedside table by surveyor. Observed V5 (Agency Registered Nurse) give R7 the two noon meds then proceeded to administer the medications from within the plastic cup that she picked up from the bedside table. On 05/13/24 at 11:56 AM, V5 (Agency Registered Nurse) said the medications she administered within the med cup were R7's 9:00 AM medications. V5 then said that she did not want to stand over R7 while she took all her pills, so she left them at the bedside. She also said that she knows she should have stayed with the resident to observe her take the medications. V5 then said the pills within the med cup administered to R7 were: losartan potassium (antihypertensive) 100mg (milligrams) one tab (tablet), metoprolol succinate (antihypertensive) ER (extended release) 50mg (3 tablets to equal 150mg), vitamin b-12 500 microgram (mcg) one tablet, amlodipine besylate (antihypertensive) 2.5 mg one tab, eliquis (blood thinner) 2.5mg one tab, ferate (iron) 27mg one tab, furosemide (diuretic) 40mg one tab. V5 then said there is a one hour window prior to and after scheduled med administration time so R7's 9:00 AM medications were administered late. V5 added that she took R7's blood pressure this morning because it should be checked prior to administration. Reconciliation of R7's active physician orders with medication administration log showed all the prescribed medications as indicated above by V5 that are scheduled for 9:00 AM with special instructions for the following medications: losartan potassium 100mg one tab hold if systolic blood pressure is less than 100, metoprolol succinate ER 50mg (3 tablets to equal 150mg) hold if systolic blood pressure is less than 110 0r pulse less than 60, and amlodipine besylate 2.5 mg one tab hold if systolic blood pressure is less than 110. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per R7's Medication Administration Record (MAR), her 9:00 AM medications were documented as being administered by V5 (Agency Registered Nurse) with her initials/signature. Surveyor did not observe V5 obtaining of R7's blood pressure prior to administering the blood pressure medications. On 05/13/24 at 12:09 PM, V5 (Agency Registered Nurse) stated that she has been a nurse for a year and knows that she should not leave medications at the bedside and should stay with resident to ensure they were taken. She added that R7 and R34 don't like for the nurse to stand over them while they take their medications, so to not cause any problems with these residents, she left their medications at the bedside. R6: On 05/13/24 at 12:15 PM, V13 (Agency Registered Nurse) said she just came in at 11:15 AM this morning because she is covering for a nurse who did not show up. She added that there is a one hour window before/after scheduled med times so all the medications she will be administering will all be late. She then said that she comes to the facility 1-2 times a week. V13 then said she never leaves meds at the bedside to ensure the right resident is receiving the right medications and added that a confused resident could wander into a room and take the medications if left at the bedside. At 12:41 PM, V13 (Agency Registered Nurse) administered the following medications to R6: fenofibrate (antilipemic) 48mg one tablet, acetaminophen (pain medication) 325mg (2 tabs), ferrous gluconate (iron) 324mg one tablet, bumetanide (diuretic) 0.5mg one tablet. She added that the rest of the medications listed on R6's MAR were for the evening medication pass. R6's active physician orders were reconciled with R6's medication administration log and noted the above mentioned medications as indicated by V13 with the following prescribed (9:00 AM) medications that were not observed as administered by V13 on 05/13/2024 but were initialed as being administered: levetiracetam (anticonvulsant) 250mg one tablet, eliquis (blood thinner) 2.5mg one tablet, potassium chloride (potassium supplement) ER 10 milliequivalent (meq), meclizine (antivertigo) 25mg one tablet. R33: On 05/13/24 at 12:49 PM, observed R33 sitting on side of bed with lunch tray set on bedside table. R33 said she was finished eating her lunch, after she ate all she wanted to eat. V13 (Agency Registered Nurse) then obtained R33's vital statistics and blood sugar then administered the following medications to her at 12:58 PM: insulin aspart (novolog) 2 units per sliding scale (scheduled for 11:00 AM), sertraline (antidepressant) hcl (hydrochloride) 50mg one tablet, aspirin (nonsteroidal antiinflammatory) ec (enteric coated) 81mg one tablet, clopidogrel (antiplatelet) 75mg one tablet, multivitamin (vitamin supplement) one tablet, ferrous sulfate (iron) 325mg one tablet, sodium bicarbonate (alkalinizing agent) 650mg one tablet, one oyster shell 500-vitamin d3 (supplement) 200mg tablet, vitamin c (viatmin supplement) 250mg one tablet. R33's active physician orders and medication administration log for R33 were reviewed and noted the following medications were not observed as administered per physician orders by V13: insulin aspart 100 unit/ml give 7 units subcutaneously before meals at 12:00 PM, gabapentin (anticonvulsant) 100 mg at 8:00 AM. Both medications were initialed as being administered by V13 (Agency Registered Nurse). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/13/24 at 02:11 PM, V2 (Director of Nursing) said today there are two agency nurses working on the second floor due to their regular nurses not being on duty today. She then said the med pass is slow today due to the system being down and an agency nurse did not show up so V3 (Quality Director) relieved the night nurse around 8:15-8:30 AM. V2 then said her expectations with the medication administration is to follow the five rights and to stay with the resident to ensure the resident is taking their medications. V2 (DON) said nurses are not to leave medications at the bed side to ensure that a confused resident doesn't wander in the room and take another resident's meds. V2 also said the medication administration window is one hour prior to and after the scheduled time so if given after that hour window, then the medication is considered late and nurses must notify the physician and document the late administration. On 05/14/24 at 02:20 PM, V17 (Nurse Practitioner) said her expectations for facility staff is to follow the five rights for each resident, observe medication administration and to check blood pressure (bp) with all bp meds. V17 then said when a medication is administered late, especially when prescribed more than once daily, the nurse should call the physician so adjustments can be made to the later administration times. On 05/15/2024 at 1:02 PM, V2 (Director of Nursing) said nurses are to administer fast-acting insulins (insulin aspart) 10-15 minutes prior to a resident eating their meal. Medication Administration policy last revised 12/2021 indicated that medications shall be administered in a safe and timely manner; shall be administered in accordance with the orders; resident may self-administer medications only if determined to do so by physician. R6, R7, R33 nor R34 have an active physician order to self-administer medications. No medication administration/physician progress notes were provided by facility for review.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 45395 Based on observation, interview, and record review, the facility failed to ensure that medical staff were properly trained to administer prescribed medications according to physician's orders and residents were free from significant medication errors. Three (R6, R7, R34) residents in the sampled medication pass of four residents (R6, R7, R33 and R34) experienced medication administration errors by the medication nurse. Findings include: R34: On 05/13/24 at 10:45 AM, observed R34 sitting in her wheelchair next to the bed with a bedside tray table in front of her. Also observed a clear, plastic medicine cup in front of resident on the bedside table that contained six pills within the cup. R34 said that her nurse had just left them a few minutes ago but she could not recall the nurse's name. She also said that she had already taken a few pills and needs to take the rest of her morning medications. When asked what these morning medications were, R34 said one is for my stomach, two are water pills, and I believe the one green pill is my iron pill. R34 could not remember what the two pink pills and one white pill were taken for but knows that she takes them every day. R34 added that if the nurse has the time, then she will stay with her to watch her take the medications. R34 then proceeded to self-administer the remaining six pills within the plastic med cup. Reconciliation of R34's active physician orders and medication administration record (MAR) for May 2024 showed the following medications as prescribed and scheduled per MAR at 9:00 AM: allopurinol (uric acid reducer) 300 milligram (mg) one tab by mouth daily, vitamin d3 (vitamin supplement) 25 microgram (mcg) one tab by mouth daily, aspirin (nonsteroidal antiinflammatory) enteric coated (ec) 81mg one tab by mouth daily, potassium citrate (urinary alkilinizer) extended release (er) 10 milliequivalent (meq) one tab by mouth daily, metolazone (diuretic) 5mg one tab by mouth daily, (certavite) senior multivitamin one tab by mouth daily, polyethylene glycol (stool softener) 3350 powder give 17 grams (g) with 6 ounce of water daily, metoprolol tartrate (antihypertensive) 50mg one tab by mouth every 12 hours (9a, 9p and hold if systolic blood pressure is below 110 or heart rate below 60), ferrous gluconate (iron supplement) 324mg one tab by mouth twice daily, magnesium oxide (supplement) 400mg one tab by mouth twice daily, metformin (antidiabetic) hcl (hydrochloride) 1000mg one tablet by mouth twice daily. Per R34's MAR, her 9:00 AM medications were documented as being administered by V5 (Agency Registered Nurse) with her initials/signature. Surveyor did not observe this documented administration by V5 or the obtaining of R34's blood pressure prior to taking the blood pressure medication. R7: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/13/24 at 11:48 AM, V5 (Agency Registered Nurse) said R7 has two medications scheduled for noon then began prepping those medications. At 11:52 AM, V5 entered R7's room to administer her noon meds when surveyor observed V5 pick up the plastic med cup that contained the nine pills that were previously observed on R7's bedside table by surveyor. V5 gave R7 the two noon meds then proceeded to administer the medications from within the plastic cup that she picked up from the bedside table. On 05/13/24 at 11:56 AM, V5 (Agency Registered Nurse) said the medications she administered within the med cup were R7's 9:00 AM medications, then said she did not want to stand over R7 while she took her pills, so she left them at the bedside. V5 also said she knows that she should stay with the residents to administer their medications and observe the residents take their meds. V5 then said the pills within the med cup administered to R7 were: losartan potassium (antihypertensive) 100mg one tab, metoprolol succinate (antihypertensive) ER (extended release) 50mg (3 tablets to equal 150mg), vitamin b-12 (supplement) 500 microgram (mcg) one tablet, amlodipine besylate (antihypertensive) 2.5 mg one tab, eliquis (blood thinner) 2. 5mg one tab, ferate (iron supplement) 27mg one tab, furosemide (diuretic) 40mg one tab. V5 then said there is a one hour window prior to and after scheduled med administration time so R7's 9:00 AM medications were administered late. V5 added that she took R7's blood pressure earlier this morning. Reconciliation of R7's active physician orders and medication administration record (MAR) for May 2024 showed the following prescribed medications scheduled per MAR at 9:00 AM and documented as being administered by V5 (Agency Registered Nurse): losartan potassium (antihypertensive) 100mg one tab, metoprolol succinate antihypertensive) ER 50mg (3 tablets to equal 150mg), vitamin b-12 (supplement) 500 microgram (mcg) one tablet, amlodipine besylate (antihypertensive) 2.5 mg one tab, eliquis (blood thinner) 2. 5mg one tab, ferate (iron supplement) 27mg one tab, furosemide (diuretic) 40mg one tab. On 05/13/24 at 12:09 PM, V5 (Agency Registered Nurse) stated that she has been a nurse for a year and knows that she should not leave medications at the bedside and should stay with resident to ensure they are taken. She added that R7 and R34 dislike for the nurse to stand over them while they take their medications, so to not cause any problems with these residents, she left their medications at the bedside. She added that moving forward, she will not leave any more medications at the bedside. R6: On 05/13/24 at 12:15 PM, V13 (Agency Registered Nurse) said she just came in at 11:15 AM this morning because she is covering for a nurse who did not show up. She added that there is a one hour window before/after scheduled med times so all the medications she will be administering will all be late. At 12:41 PM, observed V13 (Agency Registered Nurse) administer the following medications to R6: fenofibrate 48mg one tablet, acetaminophen 325mg (2 tabs), ferrous gluconate 324mg one tablet, bumetanide 0.5mg one tablet She added that the rest of the medications listed on R6's MAR were for the evening med pass. Reconciled R6's active physician orders with medication administration log and noted the medications as indicated by V13 with the following prescribed (9:00 AM) medications that were not observed as administered by V13 on 05/13/2024 but were initialed as being administered: levetiracetam (anticonvulsant) 250mg one tablet, eliquis (blood thinner) 2.5mg one tablet, potassium chloride (supplement) ER 10 milliequivalent (meq), meclizine (antivertigo) 25mg one tablet. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/13/24 at 02:11 PM, V2 (Director of Nursing) said today there is two agency nurses working on the second floor due to their regular nurses not being on duty today. She then said the med pass is slow today due to the system being down and an agency nurse did not show up so V3 (Quality Director) relieved the night nurse around 8:15-8:30 AM. V2 then said her expectations with the medication administration is to follow the five rights and to stay with the resident to ensure the resident is taking their medications. V2 (DON) said nurses are not to leave medications at the bed side to ensure that a confused resident doesn't wander in the room and take another resident's meds. V2 also said the medication administration window is one hour prior to and after the scheduled time so if given after that hour window, then the medication is considered late and nurses must notify the physician and document the late administration. On 05/14/24 at 02:20 PM, V17 (Nurse Practitioner) said her expectations for facility staff is to follow the five rights for each resident, observe medication administration and to check blood pressure (bp) with all bp meds. V17 then said when a medication is administered late, especially when prescribed more than once daily, the nurse should call the physician so adjustments can be made to the later administration times. On 05/15/2024 at 1:02 PM, V2 (Director of Nursing) said nurses are to administer fast-acting insulins (insulin aspart) 10-15 minutes prior to a resident eating their meal. Medication Administration policy last revised 12/2021 indicated that medications shall be administered in a safe and timely manner; shall be administered in accordance with the orders; resident may self-administer medications only if determined to do so by physician.