STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION	179 COMBS STREET SPARTA, NC 28675

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F 000	INITIAL COMMENTS The survey team entered the facility on 04/08/25 to conduct a complaint survey and exited on 04/08/25. Additional information was obtained on 04/09/25 and 04/10/25. Therefore, the exit date was changed to 04/10/25. The following intake was investigated: NC00228567. 1 of 4 allegations resulted in deficiency. Event ID #UIKQ11.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		5/7/25

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

Electronically Signed | 05/03/2025

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F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Nurse Practitioner, resident and staff, the facility failed to notify the physician when a one-time dose of methyl prednisolone (a steroid medication used to treat inflammatory conditions) was not administered as ordered for the treatment of an allergic reaction. The administration of methyl prednisolone was delayed five days for treatment of a rash that had worsened causing increased redness and hives, increased itching, and a low-grade fever for 1 of 1 resident reviewed for significant medication errors (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/1/24	F 580	Resident #1 rash, hives, itching and low-grade fever have resolved and there have been no further issues. Residents residing in the facility that have a one-time dose ordered have the potential to be affected by the deficient practice. An audit of residents' medication administration record was conducted by the Regional Nurse Consultant, Director of Nursing and Unit Manager on 5/2/2025 to identify those that may have missed one time medication. Any issues or concerns identified during this audit were reviewed with and adjusted by the physician or nurse practitioner. The Director of Nursing and Unit Manager	

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F 580	Continued From page 2 with diagnoses including heart failure, hypertension, and chronic pain. A review of the Nurse Practitioner (NP) progress note dated 3/5/25 revealed nursing reported Resident #1's rash had worsened, he had a low-grade fever, was very itchy and requested something stronger for a rash. The NP ordered a one-time dose of methyl prednisolone 40 mg intramuscular (IM) injection. A review of the Medication Administration Record (MAR) revealed the physician's order for methyl prednisolone 40 mg intramuscular injection was scheduled as a one-time dose on 3/5/25. On 3/5/25 at 4:38 PM Nurse #1 initialed and documented NN (see nurse note) on the MAR for the administration of methyl prednisolone. A review of the nurse note dated 3/5/25 at 4:38 PM revealed Nurse #1 documented the methyl prednisolone was on order. During a phone interview on 4/8/25 at 6:41 PM, Nurse #1 revealed she initialed the MAR for Resident #1's methyl prednisolone on 3/5/25 and added the code NN (see nurse note) to document the medication was on order. Nurse #1 revealed she did not notify the physician on 3/5/25 she had not administered the scheduled one-time dose of methyl prednisolone as ordered. Nurse #1 revealed on 3/10/25 when the NP saw Resident #1 and was made aware the injection was not given, she was instructed to administer and did. An interview was conducted on 4/8/25 at 4:53 PM with Resident #1. Resident #1 revealed he was started on clindamycin (antibiotic) and after about five days his skin broke out with red dots.	F 580	educated nurses and medication aides on notification to the physician or nurse practitioner if a medication is unable to be administered as directed. Newly hired nurses and medication aides will receive the education during orientation from the Director of Nursing. Nurses or medication aides that have not received the education by 5/7/25 will be unable to work until the education is completed. The Director of Nursing or designee will audit 5 residents medication administration records a week for 4 weeks, then 3 medication administration records a week for 4 weeks, then 1 medication administration record a week for 4 weeks to ensure that medications were administered as ordered or the physician/nurse practitioner was notified for further direction. The Director of Nursing or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed. Completion Date: May 7, 2025	

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F 580	Continued From page 3 Resident #1 revealed at first the rash appeared as small dots on his chest and arms then spread everywhere all over his body and his skin was bright red like a sunburn and itched and started peeling. Resident #1 revealed the rash was very itchy and he continuously scratched himself. A review of the NP progress note revealed on 3/10/25 Resident #1 was reevaluated for itching, an allergic reaction, and a rash nursing reported had not improved. The note revealed nursing reported the methyl prednisolone injection was still on order from pharmacy and Resident #1 had not received the medication. The NP directed nursing to call the pharmacy and ensure they delivered the injection and for nursing to give the medication when it arrived. During a phone interview on 4/8/25 at 3:29 PM and 5:33 PM, the NP revealed on 3/5/25 she saw Resident #1's rash was worse, he had low-grade fever, and she order a one-time dose of methyl prednisolone injection and wanted the medication administered the day she ordered it. The NP revealed she expected Nurse #1 to administer the methyl prednisolone IM injection and if not administered she expected to be notified within 24 hours. A phone interview was conducted on 4/10/25 at 10:00 AM with the Director of Nursing (DON). The DON revealed if methyl prednisolone was not administered as ordered on 3/5/25 she expected Nurse #1 to call the physician and request a new order to hold the medication until it arrived from the pharmacy.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		5/7/25

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F 641	Continued From page 4 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code a Minimum Data Set assessment in the area of dental for 1 of 3 residents reviewed for accuracy of assessment (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/1/24. A review of the significant change Minimum Data Set (MDS) assessment dated 8/20/24 revealed Resident #1's dental status was coded as unable to examine. During a phone interview on 4/9/25 at 4:59 PM the Administrator revealed the current MDS Coordinator was not employed when the significant change MDS was completed for Resident #1. The Administrator revealed the MDS Coordinator who completed and signed Resident #1's significant change MDS dated 8/20/24 worked remotely and no longer employed at that company and she was unable to provide their contact information. A joint phone interview was conducted on 4/10/25 at 10:26 AM with the Administrator and Director of Nursing (DON). The Administrator revealed it was the responsibility of the remote MDS Coordinator completing the dental section to the reach out to the nurse or DON if they needed a dental assessment completed for Resident #1. The	F 641	Residents #1 continues to reside in the facility and remains in stable condition. On 5/2/25 the Minimum Data Set was modified by the Director of Nursing to show that the dental status was able to be examined. On 5/2/25 the Director of Nursing completed an audit of residents Minimum Data Set in the area of dental to ensure information coded accurately reflects resident's condition. Areas of concern identified during audit were corrected immediately by the MDS nurse. On 5/2/25 the Director of Nursing educated the MDS nurse regarding accurately coding the residents' MDS to ensure information provided accurately reflects resident's condition. Newly hired MDS nurses will receive the education from the Director of Nursing during orientation. The Director of Nursing will review the dental section of 10 residents a week for 12 weeks to ensure the MDS Assessment accurately reflects the resident's current condition. The Director of Nursing will present the findings of audits to Quality Assurance Performance Improvement (QAPI) committee for review for 3 months. QAPI committee will determine trends and/or issues that may warrant further	

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F 641	Continued From page 5 DON revealed she was not contacted and after reviewing nursing documentation, a dental assessment was not completed during the lookback period when the significant change MDS was completed. Both the Administrator and DON expected the dental status of Resident #1 was accurately completed on the MDS assessment.	F 641	monitoring. Date of Compliance: May 7, 2025	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Nurse Practitioner, Director of Dental Clinical Operations and staff, the facility failed to withhold antiplatelet medication per physician's order prior to a scheduled dental visit for tooth extractions which delayed the tooth extractions for 1 of 1 resident reviewed for providing care according to professional standards (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/1/24 with diagnoses including heart failure, hypertension, and chronic pain. A review of Resident #1's current physician	F 684	Resident #1 has received the extractions and has had no further issues. Residents residing in the facility that have scheduled dental procedures have the potential to be affected by the deficient practice. The Director of Nursing reviewed the last set of dental visit notes and recommendations to ensure that orders were transcribed and completed as written. Education was completed with the nurses on transcribing orders to the MAR as ordered by the physician and/or nurse practitioner to ensure the	5/7/25

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F 684	Continued From page 6 orders included aspirin 81 milligrams (mg) give one time a day prophylactic started on 5/3/24 with no end date. (Aspirin is the most commonly used oral antiplatelet drug.) The quarterly Minimum Data Set assessment dated 8/8/24 revealed Resident #1's cognition was intact and the current medications he was taking included an antiplatelet (helps prevent blood clots). A review of the Nurse Practitioner (NP) note dated 8/26/24 revealed Resident #1 was evaluated for broken teeth. It was noted Resident #1 had not recently seen a dentist and he denied mouth pain. The NP referred Resident #1 for a dental consult. Review of the dental consent form for extractions dated 10/24/24 revealed the primary care physician was required to review Resident #1's current medications and include notes on the form. The Nurse Practitioner (NP) wrote an order to hold aspirin for three days prior to extractions and signed the form. A review of the Medication Administration Record (MAR) revealed the NP order to withhold aspirin for three days was not transcribed and from 11/1/24 through 11/6/24 nurse initials indicated they had administered aspirin to Resident #1. During a phone interview on 4/8/25 at 3:29 PM, the NP revealed the dental form dated 10/24/24 was given to her by either the Director of Nursing (DON) or Unit Manager for her to sign. The NP revealed she wanted the aspirin held for 3 days prior to extractions and it was her understanding the consent form was her physician order and	F 684	order is followed when holding a medication prior to a dental procedure. Nurses that have not received the education by 5/7/25 will not be able to work until the education is completed. Newly hired nurses will receive the education during orientation by the Director of Nursing. The Director of Nursing or designee will audit five residents a week for twelve weeks that have dental procedures with medication hold orders to ensure transcribed as ordered. The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. Completion date: May 7, 2025	

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F 684	Continued From page 7	F 684		

should have been withheld.

A review of the dental note dated 11/6/24 revealed Resident #1's teeth extractions could not be completed due to the aspirin not being withheld. The dental note did not identify Resident #1 had mouth pain.

A review of the dental note dated 1/24/25 revealed x-rays were taken and identified moderate plaque, fair oral hygiene, and red inflamed tissue and recommended routine follow-up exams. The dental exam did not identify pain.

During a phone interview on 4/8/25 at 1:03 PM the Director of Dental Clinical Operations revealed extractions were recommended for Resident #1 and scheduled for 11/6/24 but were not done due to the aspirin not being withheld. She explained on 11/6/24 if Resident #1 needed emergent dental services the dentist would have evaluated the resident, especially if pain was present, and consulted the physician.

A review of the nurse's progress note dated 2/24/25 at 12:08 PM revealed Resident #1 was seen for abscessed teeth and new orders included clindamycin (antibiotic) 300 mg every six hours for gum abscess, mouthwash swish 15 milliliters and spit out four times a day for 5 days, acetaminophen 1000 mg and ibuprofen 800 mg every six hours for 3 days.

A review of the NP progress note dated 2/28/25 revealed Resident #1 was evaluated for a follow-up of chronic conditions including a gum abscess. The NP's physical exam noted Resident #1 was in no acute distress and was calm and

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F 684	Continued From page 8	F 684		

cooperative. The NP physical exam did identify Resident #1's gums were red, edema (swelling due fluid retention) of upper left palate, tenderness to touch with no drainage, dental caries, and broken teeth. The NP noted Resident #1 denied any new concerns and continued medications as ordered.

A review of the dental note dated 3/21/25 revealed Resident #1 had 4 teeth extracted. It was noted Resident #1 was on a continuous antibiotic since his last appointment (1/24/25) for an infection and abscess. The note revealed after the extraction of a tooth exudate (pus) flowed out of the site and recommended amoxicillin/clavulanate be started.

A review of the physician's order dated 3/21/25 for amoxicillin/clavulanate 500-125 mg give two times a day for tooth extraction for seven days (14 doses).

During an interview on 4/8/25 at 4:53 PM Resident #1 revealed he received a regular textured diet and did not wish to downgrade to a mechanically altered diet. Resident #1 denied he was in pain and stated the medications he received were effective in controlling his pain.

A joint phone interview was conducted on 4/10/25 at 10:14 AM with the DON and Administrator. The DON explained their process for handling dental forms after signed by the NP was to give the form to the Unit Manager then to Resident #1's assigned nurse and the physician's order was transcribed to the MAR for the nurses to know to withhold Resident #1's aspirin. The DON and Administrator revealed they expected physician orders were followed.

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F 684	Continued From page 9 During a phone interview on 4/9/25 at 7:59 AM the Unit Manager revealed she was aware Resident #1 had been seen by the Dentist, but she did not receive his dental notes or forms.	F 684		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Nurse Practitioner, Director of Pharmacy Operations, resident and staff, the facility failed to have effective systems in place to ensure a one-time dose of an intramuscular injection of methylprednisolone (steroid) prescribed for the treatment of an allergic reaction was administered resulting in a five-day delay of it being administered. Resident #1 had an itchy rash which worsened and spread over his entire body, hives, and a low-grade fever. Resident #1 stated the rash was very itchy and he continuously scratched himself. This occurred for 1 of 1 resident reviewed for significant medication error (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/1/24 with diagnoses including heart failure and chronic pain. A review of the nurse progress note revealed on 2/24/25 Resident #1 was evaluated by the Nurse Practitioner (NP) for an abscess. The NP's	F 760	Resident #1 resides in the facility and there have been no further issues. Resident received the methyl prednisolone on 3/10/25. Residents with a one-time medication dose of medication ordered have the potential to be affected. An audit was conducted on 5/2/25 of the last 30 days to identify residents who may have missed a one-time medication order. Residents identified during the audit would be reported to the NP/MD for further direction. The Unit Manager and Director of Nursing educated nurses and medication aides on proper medication administration practices. Any nurse or medication aide that does not receive the education by 5/7/25 will not be able to work until the education is completed. Newly hired nurses and medication aides will receive the education in orientation from the Director of Nursing.	5/7/25

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F 760	Continued From page 10 treatment plan included a new order for clindamycin (antibiotic) 300 milligrams (mg) every 6 hours for seven days for a gum abscess. A review of the NP progress note dated 2/28/25 revealed Resident #1 continued to receive clindamycin for a gum abscess and denied any side effects, was doing a little better, and had no new concerns. The NP made no changes and continued Resident #1's medications as ordered. A review of the NP progress note dated 3/4/25 revealed nursing reported Resident #1 now had an itchy rash. The NP's physical exam noted Resident #1 had an erythematous (redness and inflammation of the skin) rash, hives and was itchy. Resident #1 denied shortness of breath, chest pain, trouble swallowing, or palpitations and the NP ordered to discontinue clindamycin. The NP's treatment plan included sulfamethoxazole-trimethoprim (antibiotic) DS (double strength) give one tablet twice a day for 10 days (20 doses), germicidal mouthwash 15 milliliters swish and spit twice a day, and diphenhydramine (antihistamine) 25 mg give one dose now. A review of the physician orders dated 3/4/25 included sulfamethoxazole-trimethoprim DS 800-100 mg give one tablet twice a day for abscess for 10 days, germicidal mouthwash 15 ml swish and spit two times a day for oral abscess with no end date, and diphenhydramine 25 mg give 1 tablet one time only for allergies. A review of the Medication Administration Record (MAR) revealed sulfamethoxazole-trimethoprim DS was initialed by nurses with the first dose administered on 3/4/25 at 9:00 PM and continued	F 760	The Director of Nursing or designee will audit 5 medication administration records a week for 4 weeks, then 3 medication administration records a week for 4 weeks, then 1 medication administration record a week for 4 weeks to ensure appropriate administration and documentation of one-time medication orders. The Director of Nursing or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed. Completion Date: May 7, 2025	

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through 3/12/25 at 9:00 AM (20 doses), germicidal mouthwash 15 milliliters swish and spit twice a day was started on 3/4/25 and initialed by nurses it was administered twice a day with no end date, diphenhydramine 25 mg give one time only for allergies was initialed by the nurse as given on 3/4/25 at 10:00 AM.

A review of the physician orders started on 3/5/25 revealed prednisone (a steroid) 20 mg give one tablet daily for 3 days for rash, hydroxyzine (antihistamine) 25 mg give one tablet twice a day for 3 days and as needed every eight hours for 7 days for itching, clobetasol propionate external cream (steroid cream) apply to body topically twice a day for 14 days for rash.

A review of the MAR revealed prednisone 20 mg was initialed as administered by the nurses on 3/5/25 through 3/7/25, hydroxyzine 25 mg give one tablet twice a day for 3 days initialed as administered by the nurses on 3/6/25 through 3/8/25 with one as needed dose given on 3/9/25 that was effective, and clobetasol propionate external cream apply to body topically twice a day for 14 days for rash started on 3/5/25.

A review of the NP progress note dated 3/5/25 revealed nursing reported Resident #1's rash was worse, he had a low-grade fever of 100.7, was very itchy and requesting something stronger for the rash. The physical exam noted the erythematous rash had spread all over, hives, and mild skin peeling on the upper chest. The NP ordered a one-time dose of methyl prednisolone 40 mg intramuscular injection.

The physician's order for methyl prednisolone inject 40 mg intramuscular one time only for rash

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started on 3/5/25 with an end date of 3/5/25.

A review of the MAR revealed Nurse #1 initialed and documented NN (see nurse note) on 3/5/25 at 4:38 PM for methyl prednisolone inject 40 mg intramuscular one time only for rash.

A review of the nurse note dated 3/5/25 revealed Nurse #1 documented the methyl prednisolone was on order.

A review of the facility's backup medication supply list revealed three doses of 40 mg methyl prednisolone intramuscular injections were available on 3/5/25.

A review of the physician's order dated 3/9/25 for methyl prednisolone inject 40 mg intramuscularly one time for rash was restarted on 3/9/25.

During a phone interview on 4/8/25 at 6:41 PM Nurse #1 revealed she worked the day shift on 3/5/25 and her initials on the MAR meant she was supposed to administer Resident #1's intramuscular injection of methyl prednisolone. She revealed the medication was not on the medication cart and she asked a nurse she did not recall and was told methyl prednisolone was not in the backup medication storage supply. She informed the oncoming nurse the methyl prednisolone injection was not administered and thought after it was delivered by pharmacy that nurse would give the injection. Nurse #1 revealed she did not hear anything about the injection until 3/9/25 when the Unit Manager told her to call the pharmacy and have them deliver the medication. Nurse #1 revealed if the methyl prednisolone was delivered on 3/9/25 she thought the nurse would administer it after delivery. Nurse #1 stated she

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administered methyl prednisolone to Resident #1 on 3/10/25 as directed by the NP.

A review of the NP progress note dated 3/10/25 revealed nursing reported Resident #1's rash had not improved, and he was still very itchy. The NP directed nursing to call pharmacy and ensure they delivered the steroid (methyl prednisolone) injection and directed nursing to give the medication when it arrived.

A review of the MAR revealed on 3/10/25 Nurse #1 initialed methyl prednisolone inject 40 mg intramuscularly to indicate the medication was administered.

A phone interview was conducted on 4/8/25 at 3:29 PM and 5:33 PM with the NP. The NP revealed Resident #1 was started on oral prednisone on 3/5/25 for a rash she attributed as an allergic reaction to clindamycin. The oral prednisone was not as effective and when the NP saw Resident #1 on 3/5/25 the rash was worse and he had a low-grade fever and wanted something stronger, so she ordered a one-time dose of methyl prednisolone intramuscular injection. On 3/10/25 she was at the facility and made aware the injection was not administered and she still wanted Resident #1 to receive it. The NP revealed she expected methyl prednisolone was administered on 3/5/25 when she ordered it and considered it as a medication error if not. She revealed a 40 mg of methyl prednisolone was a standard dose and Resident #1 had received oral and topical medications to help relieve his symptoms and did not have shortness of breath or chest pain and she did not think there was a negative outcome it was delayed for five days.

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A phone interview was conducted on 4/9/25 at 10:16 AM with the Director of Pharmacy Operations. After review of methyl prednisolone ordered on 3/5/25, the Director stated the order was received after the cutoff time and the expectation for a one-time dose the nurse would need to access the medication from the backup storage system. The Director revealed a second order was received and delivered by pharmacy on 3/9/25. After reviewing the transactions made from the backup medication storage system the Director revealed methyl prednisolone was not removed and the quantity on hand remained at three doses and no transactions were made for March 2025.

An interview was conducted on 4/8/25 at 4:53 PM with Resident #1. Resident #1 revealed he had an infected tooth and was started on clindamycin and after about five days his skin broke out with red dots. Resident #1 revealed at first the rash appeared as small dots on his chest and arms then spread everywhere all over his body and his skin was bright red like a sunburn and itched and started peeling. Resident #1 revealed the rash was very itchy and he continuously scratched himself.

A joint phone interview was conducted on 4/10/25 at 10:00 AM with the Director of Nursing (DON) and Administrator. The DON and Administrator were asked if methyl prednisolone was available in the backup storage medication supply did they expect Nurse #1 to administer the medication as ordered on 3/5/25. The DON revealed she expected Nurse #1 to check the backup medication supply and administer methyl prednisolone injection as ordered and if the medication was not administered provide that

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F 760	Continued From page 15 information to the oncoming nurse to ensure it was. The Administrator and DON revealed Resident #1 was getting oral prednisone and other medications to help relieve his allergic reaction symptoms. The DON revealed not administering methyl prednisolone was a medication error and the NP was closely monitoring Resident #1 and with other medication treatments in place she did not feel the delay in administration was a significant medication error.	F 760		