STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075317	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilton Meadows Health Care Center	439 Danbury Rd, Route 7 Wilton, CT 06897

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents reviewed for medication errors, (Resident #1), the facility failed to ensure a significant medication error was reported timely to the physician. The findings include: Resident #1 was admitted to the facility on [DATE] for palliative care with diagnoses that included cirrhosis, heart failure, chronic kidney disease, and severe sepsis with septic shock. The admission assessment dated [DATE] identified Resident #1 was alert, oriented to person place, time, and situation. The baseline care plan dated 4/19/24 identified Resident #1 at danger for reoccurrence of acute medical condition with interventions directing to administer medications per MD orders and vital signs per facility protocol. The physician's order dated 4/19/24 at 8:05 P.M. directed to administer morphine solution 2 mg per /1 ml oral solution, amount 2.5 ml, every 4 hours around the clock. Review of the facility's accident and incident report form dated 4/20/24 without a time of the event identified on 4/20/24 at 4:00 A.M., 8:00 A.M., and 12:00 P.M. identified erroneous morphine doses were administered to Resident #1. Review of Resident #1's Controlled Substance Disposition Record (a form that records how much of a controlled substance is administered) dated 4/20/24 identified that Omnicell House Stock morphine sulfate 100 mg/5 ml was retrieved on 4/20/24 by RN #3 and provided to Licensed Practical Nurse (LPN) #2 in the amount of 15 ml's. The narcotic disposition record identified that on 4/20/24 at 4:00 A.M. LPN #2 administered 2.5 ml's to Resident #1. On 4/20/24 at 8:00 A.M. and 12:00 P.M. RN #4 administered 2.5 ml's to Resident #1. (the resident received 2.5 ml of the 100 mg/5 ml concentration, which was a dose of 50 mg, 10 times the ordered dose on 3 separate occasions). (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: 075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 439 Danbury Rd, Route 7 Wilton, CT 06897	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's progress note dated 4/20/24 at 8:28 written by RN #1 indicated she assessed Resident #1 after a report of Resident #1 receiving the wrong dose of morphine sulfate 3 times at 4 AM, 8 AM, and 12 PM. Resident #1's vital signs are temperature: 96.5, heart rate: 110, blood pressure: 94/68, respiratory rate 16, and oxygen saturation level of 95% on 2 liters of oxygen. RN #1 indicated Resident #1 is on palliative care and lungs are clear bilaterally with diminished sounds at bases. RN #1 identified Resident #1's oxygen saturation level was 88 % on room air, placed on oxygen via nasal cannula at 2 liters per minute, and the oxygen saturation level increased to 95%. RN #1 indicated Resident #1 was offered to be sent to the hospital and refused. Interview with RN #1 on 5/21/24 at 11:55 A.M. identified on 4/20/24 at approximately 4:00 P.M. she was notified by LPN #1 that a medication error was made and Resident #1 received the wrong dose of morphine at 4 A.M., 8:00 A.M., and 12:00 P.M. RN #1 identified on 4/20/24 although she was aware of the medication error at 4:00 P.M. she did not notify the physician until approximately 7:00 P.M. (3 hours after the error was identified) because she was trying to figure out what occurred with the medication error. Interview with the Medical Director (MD #1) on 5/22/24 at 10:05 A.M. he identified he would have expected immediate notification to the physician on-call about the medication error. Interview with the Director of Nurses (DNS) on 5/22/24 at 10:55 A.M. identified on 4/20/24 at approximately 7:00 P.M. he was notified by RN #1 that there was a medication error, and that Resident #1 received the wrong dose of morphine for 3 doses on 4/20/24. The DNS identified his expectations are when a medication error occurs, the physician is notified immediately. The facility's adverse consequences and medication errors policy last revised April 2014, directed in part, the physician is notified promptly of any significant medication error and the incident is forwarded to the director of nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER: Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 439 Danbury Rd, Route 7 Wilton, CT 06897	

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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 0658 Level of Harm - Immediate jeopardy to resident health or safety 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** 40172 Based on record review and interviews for one (1) of three (3) residents reviewed for medication errors (Resident #1), the facility failed to ensure that multiple nurses followed the five rights of medication administration in accordance with nursing standards of practice. Resident #1 was administered morphine (an opioid pain medication) at ten (10) times the prescribed dose on three separate occasions resulting in a finding of Immediate Jeopardy. The findings include: Resident #1 was admitted to the facility in April 2024 under palliative care with diagnoses that included cirrhosis, heart failure, chronic kidney disease, and severe sepsis with septic shock. The nursing admission assessment dated [DATE] identified Resident #1 was alert, oriented to person place, time, and situation. The baseline care plan dated 4/19/24 identified Resident #1 at risk for reoccurrence of acute medical conditions with interventions directed to administer medications per MD orders and vital signs per facility protocol. Review of Resident #1's W-10 (a form sent from the hospital to the skilled nursing facility that includes medication orders) dated 4/19/24 directed to administer morphine (a narcotic pain medication) 2 milligrams (mg) per 1 milliliter (ml) oral solution, give 2.5 ml oral, every four (4) hours. The order did not specify the dosage in milligrams. (The order would equate to a 5 mg dose every 4 four hours). The physician's order dated 4/19/24 directed to administer morphine solution 2 mg/1 ml, total amount to be administered 2.5 ml, every four (4) hours around the clock. The order did not specify the dosage in milligrams. A nurse's note dated 4/19/24 at 11:31 P.M. written by Registered Nurse (RN) #3 identified the admitting orders (including the physician's order for morphine) were verified and approved by Advanced Practice Registered Nurse (APRN) #1. Review of Resident #1's Controlled Substance Disposition Record (a form that records how much of a controlled substance is administered) dated 4/20/24 identified that Omnicell House Stock morphine sulfate 100 mg/5 ml was retrieved on 4/20/24 by RN #3 and provided to Licensed Practical Nurse (LPN) #2. The narcotic disposition record identified that on 4/20/24 at 4:00 A.M. LPN #2 administered 2.5 ml's (100 mg/ 5 ml) to Resident #1. On 4/20/24 RN #4 administered 2.5 ml's (100 mg/ 5 ml) to Resident #1 at 8:00 A.M. and 12:00 P.M. Review of the Medication Administration Record (MAR) identified on 4/20/24 at 4:00 A.M. LPN #2 administered 2.5 ml's of 2 mg/1 ml morphine solution to Resident #1. On 4/20/2024 at 8:00 A.M. and 12:00 P.M. RN #4 administered 2.5 ml's of 2mg/1 ml morphine solution to Resident #1. Review of the facility's accident and incident report form dated 4/20/24 identified on 4/20/24 at 4:00 A.M, 8:00 A.M, and 12:00 P.M. erroneous morphine doses were administered to Resident #1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilton Meadows Health Care Center	439 Danbury Rd, Route 7 Wilton, CT 06897

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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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nurse's note dated 4/20/24 at 8:28 P.M. written by RN #1 identified Resident #1 was assessed after a report of receiving the incorrect dose of morphine sulfate three (3) times at 4:00 AM, 8:00 AM, and 12:00 PM. RN #1 identified Resident #1 was on palliative care, lungs clear bilaterally with diminished sounds at bases. RN #1 identified Resident #1's oxygen saturation level was 88 % on room air (normal oxygen saturations are between 90-100%), the resident was placed on oxygen via nasal cannula at two (2) liters per minute, and oxygen saturation level increased to 95%. RN #1 indicated Resident #1 was offered to be sent to the hospital and refused. A nurse's note dated 4/21/24 at 2:25 AM indicated that the resident was nauseous, pale, diaphoretic, has slurred words, and vomiting. The physician was notified, and the resident was sent to the hospital. Interview with RN #3 on 5/22/24 at 8:53 A.M. identified that she was the nursing supervisor on the 11:00 PM to 7:00 AM shift on 4/19/24 into 4/20/24 and on 4/20/24 LPN #2 reported that she did not have morphine to administer to Resident #1. RN #3 identified she retrieved the morphine solution for Resident #1 from the Omnicell (an automated machine that dispenses medications) house stock and handed it to LPN #2. RN #3 could not recall if she looked at the strength/concentration of the morphine solution prior to giving it to LPN #2. Interviews with LPN #2 on 5/28/24 at 8:00 AM identified that she worked the 11:00 PM to 7:00 AM shift on 4/19 into 4/20/24 and she did not have the scheduled 4:00 AM dose of morphine to administer to Resident #1, as it had not come in from the pharmacy. LPN #2 stated that she informed the nursing supervisor (RN #3) that she needed the medication for Resident #1, and RN #3 retrieved the medication from the Omnicell. LPN #2 identified that RN #3 gave her the bottle of morphine from the Omnicell, and although she looked at the medication bottle and identified it was morphine prior to administration, she failed to identify that the concentration of the medication was 100 mg/5 ml instead of the 2 mg/1 ml as ordered by the physician. She administered 2.5 ml's of the 100 mg/5 ml concentration (50 mg) for the 4:00 AM dose to Resident #1, for a total dose of 50 mg instead of the ordered 5 mg. Interview with RN #4 on 5/28/24 at 7:34 AM identified she worked the 7:00 AM to 3:00 PM shift on 4/20/24 and administered the 8:00 AM and the 12:00 PM dose of morphine to Resident #1. RN #4 identified that she thought she looked at the label of the morphine solution concentration prior to administration, however she did not identify that the concentration of the morphine was 100 mg/5 ml prior to administration. RN #4 identified that she administered 2.5 ml's of the 100 mg/5 ml morphine solution instead of the ordered solution 2.5 ml's of morphine 2 mg/1 ml (which was two (2) doses of 50 mg instead of 5 mg, (10 times the ordered dose). Interview with LPN #1 on 5/22/24 at 3:45 P.M. identified that she worked the 3:00 PM to 11:00 PM shift on 4/20/24 and when counting narcotics with RN # 4 on 4/20/24 she identified by looking at the narcotic disposition form that the concentration of morphine given to Resident #1 was 100 mg/5 ml, and not 2 mg/1 ml as the physician's order directed. LPN #1 identified based on her calculations Resident #1 received 50 mg of morphine for each of the last 3 doses (the resident should have received 5 mg each dose according to the physician's order). LPN #1 identified she notified RN #1 that there was a medication error. (continued on next page)

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Wilton Meadows Health Care Center	439 Danbury Rd, Route 7 Wilton, CT 06897

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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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN #1 on 5/21/24 at 11:55 A.M. identified on 4/20/24 at approximately 4:00 P.M. she was notified by LPN #1 that a medication error was made, and Resident #1 received the wrong dose of morphine at 4:00 A.M., 8:00 A.M., and 12:00 P.M. RN #1 identified she assessed the Resident with an oxygen saturation of 88%. She applied oxygen, monitored the resident, and notified the physician. Interview with the Medical Director (MD #1) on 5/22/24 at 10:05 A.M. identified his expectations are that the nurses read the labels of all medications prior to administration to ensure the correct dose is administered in accordance with physician's orders. MD #1 identified LPN #2 and RN #4 should have read the label on the morphine solution and checked the strength/concentration prior to administering the morphine to Resident #1. MD #1 identified if the facility only had the 100 mg/5 ml of morphine on hand they could have called the on-call physician to obtain a new order to adjust the dose because the concentration was stronger than what was initially ordered for Resident #1. Interview with the Director of Nurses (DNS) on 5/21/24 at 11:00 A.M. identified LPN #2 and RN #4 administered the wrong dose of morphine to Resident #1 on 4/20/24 at 4:00 A.M., 8:00 A.M. and 12:00 P.M. The DNS identified the cause of the medication error was because LPN #2 and RN #4 did not read the concentration of the morphine prior to administration, and administered the 100mg/5ml concentration of morphine instead of the physician ordered concentration of 2 mg/ 1ml. The DNS identified that he expects the 5 rights of medication administration (right resident, right medication, right dose, right time, and right route) to be followed by all nurses. According to Fundamentals of Nursing: 11th edition, Mosby, [NAME] and [NAME], 2022: To prevent medication errors nurses must follow the five rights of medication administration consistently every time medications are administered. The five rights of medication administration include the right medication, right dose, right resident, right route, and right time.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172 Based on record review and interviews for one (1) of three (3) residents reviewed for medication administration (Resident #1), the facility failed to ensure the that the resident was free from a significant medication error. Two (2) nurses failed to check the strength/concentration of morphine (an opioid pain medication) prior to administration, and administered the medication at ten (10) times the prescribed dose on three (3) separate occasions, resulting in a finding of Immediate Jeopardy. The findings include: Resident #1 was admitted to the facility in April 2024 under palliative care with diagnoses that included cirrhosis, heart failure, chronic kidney disease, and severe sepsis with septic shock. The nursing admission assessment dated [DATE] identified Resident #1 was alert, oriented to person place, time, and situation. The baseline care plan dated 4/19/24 identified Resident #1 at risk for reoccurrence of acute medical conditions with interventions directed to administer medications per MD orders and vital signs per facility protocol. Review of Resident #1's W-10 (a form sent from the hospital to the skilled nursing facility that includes medication orders) dated 4/19/24 directed to administer morphine (a narcotic pain medication) 2 milligrams (mg) per 1 milliliter (ml) oral solution, give 2.5 ml oral, every four (4) hours. The order did not specify the dosage in milligrams. (The order would equate to a 5 mg dose every 4 four hours). The physician's order dated 4/19/24 directed to morphine solution 2 mg/1 ml, total amount to be administered 2.5 ml, every 4 hours around the clock. The order did not specify the dosage in milligrams. A nurse's note dated 4/19/24 at 11:31 P.M. written by Registered Nurse (RN) #3 identified the admitting orders (including the physician's order for morphine) were verified and approved by Advanced Practice Registered Nurse (APRN) #1. Review of Resident #1's Controlled Substance Disposition Record (a form that records how much of a controlled substance is administered) dated 4/20/24 identified that Omnicell House Stock morphine sulfate 100 mg/5 ml was retrieved on 4/20/24 by RN #3 and provided to Licensed Practical Nurse (LPN) #2 in the amount of 15 ml's. The narcotic disposition record identified that on 4/20/24 at 4:00 A.M. LPN #2 administered 2.5 ml's (100 mg/ 5 ml) to Resident #1. On 4/20/24 RN #4 administered 2.5 ml's (100 mg/ 5 ml) to Resident #1 at 8:00 A.M. and 12:00 P.M. (Fifty (50) mg's of morphine was administered each time.) . Review of the Medication Administration Record (MAR) identified on 4/20/24 at 4:00 A.M. LPN #2 administered 2.5 ml's of 2 mg/1 ml morphine solution to Resident #1. On 4/20/2024 at 8:00 A.M. and 12:00 P. M. RN #4 administered 2.5 ml's of 2mg/1ml morphine solution to Resident #1. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 439 Danbury Rd, Route 7 Wilton, CT 06897	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's accident and incident report form dated 4/20/24 identified on 4/20/24 at 4:00 A.M, 8:00 A.M, and 12:00 P.M. erroneous morphine doses were administered to Resident #1. A nurse's note dated 4/20/24 at 8:28 P.M. written by RN #1 identified Resident #1 was assessed after a report of receiving the incorrect dose of morphine sulfate three (3) times at 4:00 AM, 8:00 AM, and 12:00 PM. RN #1 identified Resident #1 was on palliative care, lungs clear bilaterally with diminished sounds at bases. RN #1 identified Resident #1's oxygen saturation level was 88% on room air (normal oxygen saturations are between 90-100%), the resident was placed on oxygen via nasal cannula at two (2) liters per minute, and oxygen saturation level increased to 95%. RN #1 indicated Resident #1 was offered to be sent to the hospital and refused. A nurse's note dated 4/21/24 at 2:25 AM indicated that the resident was nauseous, pale, diaphoretic, slurring words, and vomiting. The physician was notified, and the resident was sent to the hospital. Interview with RN #3 on 5/22/24 at 8:53 A.M. identified that she was the nursing supervisor on the 11:00 PM to 7:00 AM shift on 4/19/24 into 4/20/24) and on 4/20/24 LPN #2 reported that she did not have morphine to administer to Resident #1. RN #3 identified she retrieved the morphine solution for Resident #1 from the Omnicell (an automated machine that dispenses medications) house stock and handed it to LPN #2. RN #3 could not recall if she looked at the strength/concentration of the morphine solution prior to giving it to LPN #2. Interviews with LPN #2 on 5/28/24 at 8:00 AM identified that she worked the 11:00 PM to 7:00 AM shift on 4/19 into 4/20/24 and she did not have the scheduled 4:00 AM dose of morphine to administer to Resident #1, as it had not come in from the pharmacy. LPN #2 stated that she informed the nursing supervisor (RN #3) that she needed the medication for Resident #1, and RN #3 retrieved the medication from the Omnicell, LPN #2 identified that RN #3 gave her the bottle of morphine from the Omnicell, and although she looked at the medication bottle and identified it was morphine prior to administration, she failed to identify that the concentration of the medication was 100 mg/5 ml instead of the 2 mg/1 ml as ordered by the physician. She administered 2.5 ml's of the 100 mg/5 ml concentration (50 mg) for the 4:00 AM dose to Resident #1, for a total dose of 50 mg instead of the ordered 5 mg. Interview with RN #4 on 5/28/24 at 7:34 AM identified she worked the 7:00 AM to 3:00 PM shift on 4/20/24 and administered the 8:00 AM and the 12:00 PM dose of morphine to Resident #1. RN #4 identified that she thought she looked at the label of the morphine solution concentration prior to administration, however she did not identify that the concentration of the morphine was 100 mg/5 ml. prior to administration. RN #4 identified that she administered 2.5 ml's of the 100 mg/5 ml morphine solution instead of the ordered solution 2.5 ml's of morphine 2 mg/1 ml (which was two (2) doses of 50 mg instead of 5 mg, (10 times the ordered dose). Interview with LPN #1 on 5/22/24 at 3:45 P.M. identified that she worked the 3:00 PM to 11:00 PM shift on 4/20/24 and when counting narcotics with RN # 4 on 4/20/24 she identified by looking at the narcotic disposition form that the concentration of morphine given to Resident #1 was 100 mg/5 ml, and not 2 mg/1 ml as the physician's order directed. LPN #1 identified based on her calculations Resident #1 received 50 mg of morphine for each of the last 3 doses (instead of the 5 mg dose ordered by the physician) . LPN #1 identified she notified RN #1 that there was a medication error. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN #1 on 5/21/24 at 11:55 A.M. identified on 4/20/24 at approximately 4:00 P.M. she was notified by LPN #1 that a medication error was made, and Resident #1 received the wrong dose of morphine at 4:00 A.M., 8:00 A.M., and 12:00 P.M. RN #1 identified she assessed the Resident with an oxygen saturation of 88%, applied oxygen, and monitored the resident and notified the physician. Interview with the Medical Director (MD #1) on 5/22/24 at 10:05 A.M. identified his expectations are that the nurses read the labels of all medications prior to administration to ensure the correct dose is administered in accordance with physician's orders. MD #1 identified LPN #2 and RN #4 should have read the label on the morphine solution and checked the strength/concentration prior to administering the morphine to Resident #1. MD #1 identified if the facility only had the 100 mg/5 ml of morphine on hand they could have called the on-call physician to obtain a new order to adjust the dose because the concentration was stronger than what was initially ordered for Resident #1. Interview with the Director of Nurses (DNS) on 5/21/24 at 11:00 A.M. identified LPN #2 and RN #4 administered the wrong dose of morphine to Resident #1 on 4/20/24 at 4:00 A.M., 8:00 A.M. and 12:00 P.M. The DNS identified the cause of the medication error was because LPN #2 and RN #4 did not read the concentration of the morphine prior to administration. LPN #2 and RN #4 administered the 100 mg/5 ml concentration of morphine not the physician's ordered morphine concentration 2 mg/1 ml. The DNS identified that he expects the 5 rights of medication administration (right resident, right medication, right dose, right time, and right route) to be followed by all nurses. The facility medication administration policy last revised April 2019, directed in part, the individual administering medications checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, right method (route) of administration before giving the medication. Refer to F658.

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NAME OF PROVIDER OR SUPPLIER Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 439 Danbury Rd, Route 7 Wilton, CT 06897	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on clinical record review, facility documentation review, facility policy review, and interviews for one (1) of three (3) residents reviewed for medication errors, (Resident #1), the facility failed to ensure the clinical record was complete and accurate to include vital signs. The findings include: Resident #1 was admitted to the facility on [DATE] for palliative care with diagnoses that included cirrhosis, heart failure, chronic kidney disease, and severe sepsis with septic shock. The admission assessment dated [DATE] identified Resident #1 was alert, oriented to person place, time, and situation. The baseline care plan dated 4/19/24 identified Resident #1 at danger for re-occurrence of acute medical condition with interventions directing to administer medications per MD orders and vital signs per facility protocol. The physician's order dated 4/19/24 at 8:05 P.M. directed to administer morphine solution 2 mg per 1 ml oral solution, amount 2.5 ml, every 4 hours around the clock. Review of the facility's accident and incident report form dated 4/20/24 without time of event identified on 4/20/24 at 4:00 A.M., 8:00 A.M., and 12:00 P.M. identified erroneous morphine doses were administered to Resident #1, the physician was contacted and ordered vital signs on the resident every 2 hours. A nurse's progress note dated 4/20/24 at 8:28 PM written by RN #1 indicated she assessed Resident #1 after a report of Resident #1 receiving the wrong dose of morphine sulfate three (3) times at 4:00 AM, 8:00 AM, and 12:00 PM. Resident #1's vital signs are temperature: 96.5, heart rate: 110, blood pressure: 94/68, respiratory rate 16, and oxygen saturation level of 95% on 2 liters of oxygen. RN #1 indicated Resident #1 is on palliative care and lungs are clear bilaterally with diminished sounds at bases. RN #1 identified Resident #1's oxygen saturation level was 88 % on room air, placed on oxygen via nasal cannula at 2 liters per minute, and the oxygen saturation level increased to 95%. RN #1 indicated Resident #1 was offered to be sent to the hospital and refused. Review of Resident #1's vital signs flowsheet identified on 4/20/24 at 9:21 P.M. Resident #1's blood pressure was recorded as 94/68 with no documentation of Resident #1's temperature, pulse, oxygen saturation level, nor respirations. On 4/20/24 at 10:55 P.M. Resident #1's temperature was 97.8 degrees, pulse was 110 beats per minute, respirations were 18 per minute, and blood pressure was 94/68. Resident #1's full set of vital signs were not recorded on 4/20/24 at 9:00 P.M., and on 4/21/24 at 1:00 A.M. Interview with LPN #2 on 5/22/24 at 9:00 AM identified that she did a full set of vitals every 2 hours starting at 7:00 PM for Resident #1, although maybe she had not documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilton Meadows Health Care Center	439 Danbury Rd, Route 7 Wilton, CT 06897

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #4 on 5/23/24 at 3:10 PM identified that she had taken the resident's vital signs at 1:00 AM, and they were baseline for the resident, however, she may have forgotten to document the vital signs. Interview with the Medical Director (MD #1) on 5/22/24 at 10:05 A.M. he identified on 4/20/24 when the medication error was identified he would have expected that Resident #1's vital signs were being monitored every 2 hours and recorded in the clinical record. Interview and review of Resident #1's vital signs flowsheet with the Director of Nursing Services on 5/22/24 at 10:55 P.M. it was his expectation following the medication error on 4/20/24 Resident #1's vital signs should have been monitored and recorded every 2 hours. The DON identified and confirmed through review that Resident #1's vital signs were not documented in the clinical record every 2 hours. The facility's charting errors and omissions policy identified accurate medical records shall be maintained by this facility.