STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145343	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Nursing & Rehab Center	4900 North Bernard Chicago, IL 60625

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. (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to notify a physician of a residents (R7) condition/status. This failure affected 1 resident in the total sample of 10 residents.Findings include:R6 has a diagnosis which include but are not limited to: Repeated falls, Alzheimer's disease, lack of coordination, abnormalities of gait and mobility, weakness, dementia, ataxic gait, unsteadiness on feet, and insomnia. R6 has a Brief Interview for Mental Status (BIMS) dated 07/10/25 with no score and indicates that R6 has memory impairments.R7 has a diagnosis which includes but are not limited to: cocaine abuse, disorientation, other disorders of the brain, cerebral infarction, cerebral ischemia, and anxiety.R7 has a Brief Interview for Mental Status (BIMS) dated 04/30/25 with a score of 6 and indicates that R6 has memory impairments. During this survey R6 was able to answer surveyor questions appropriately.On 07/15/25 at 11:30 am, Surveyors observed V23 (Licensed Practical Nurse, LPN) (R6 and R7's nurse on 07/13/25) leave the facility via 911 emergency due to V23 not feeling well. On 07/15/25 at 1:07 pm, V12 (R6's Family Member) stated that on 07/13/25 V12 received a phone call from V23 (LPN) stating that V23 turned away from R6 for one second and R6 was pushed by R7 onto the floor. V12 also explained that V23 informed V12 that R6 was going to the local hospital for and evaluation. V12 stated that the local hospital informed V12 that R6 sustained a left hip fracture. V12 then explained that on 07/14/25 V12 came to the facility and informed V1 (Administrator) at facility that V12 filed a police report number JJ333620 regarding R7 pushing R6 onto the floor causing R6 to sustain a left hip fracture. On 07/16/25 at 9:31 am, V1 (Administrator) informed surveyors that V23 was a admitted to the local hospital. Surveyor was not able to interview V23 for this investigation. On 07/16/25 at 9:52 am, R7 stated that a few days ago R7 was standing at the elevator when R6 kept approaching R7. R7 stated that R7 told R6 Get the F*** away from me and pushed R6 away from R7. R7 explained that R6 landed on the floor after R7 pushed R6. R7 then stated, I didn't throw her down. I pushed her. R7 then reiterated that R7 kept yelling at R6 Stay away from me and that R6 didn't. On 07/16/25 at 10:23 am, V22 (Certified Nursing Assistant, CNA) denied that V22 was assigned to R6 or R7 on 07/13/25 and does not know where V25 (CNA) and V26 (CNA) (who were assigned to R6 and R7) were located on the unit during the time of R6 and R7's incident. V22 explained that V22 believes that V25 and V26 were down the hallway gathering their belongings to leave for the day. V22 further explained that V22 was at the nurse's station on 07/13/25 during the time of the incident with R6 and R7. V22 then stated that V22 recalls R6 standing in front of R7 at the nurses station, elevator area when R7 was telling R6 to get out of her (R7's) face. V22 further explained that R6 kept walking into R7's face when R7 turned around and put her (R7's) hand out in front of R6 making contact with R6's chest causing R6 to fall onto the floor. V22 further explained that V22 was behind the nurse's station when the incident occurred and was gathering her belongings to go home. V22 then explained that by the time she came from around the nurse's station to R6 and R7, R6 was already on the floor. V22 also explained that V23 (Licensed Practical Nurse, LPN) R6 and R7's assigned nurse was down the third-floor unit hallway still passing medications and that V24 (Registered Nurse, RN) was sitting at the nurse's station charting. V22 explained that V22 and V23 (LPN) assisted R6 off the floor. On 07/17/25 at 10:35 am, V28 (On Call Physician) (R6 physician on 07/13/25) stated that on 7/13/25 V28 received a call from the facility that staff witnessed R6 falling backwards onto R6's back area and complained of facial grimaces. V28 explained that staff informed V28 that R6 was a resident who walked with an unsteady gait and was roaming the nurses station area when R6 fell. V28 stated that residents who ambulate with and unsteady gait should be placed in a fall supervision program and supervised by staff at all times when walking to avoid the resident from falling and sustaining an injury. V28 further explained that V28 gave orders for R6 to be sent out to the local hospital for an evaluation to rule out fractures. V28 then stated that V28 was informed that R6 sustained a hip fracture due to R6's fall on 07/13/25. When V28 was asked regarding R7's aggressive behaviors, V28 explained that when staff called V28 at the time of R6's fall on 07/13/25, staff at the facility did not inform V28 regarding R7 being involved with R6's fall on 07/13/25 until right before the surveyor spoke with V28 on 07/17/25. V28 stated, If I was made aware that there was a fight, I would have ordered interventions to address R7's behaviors such as possibly ordering a mood stabilizer, placing R7 on one-to-one monitoring, and sending R7 out to the local hospital for a psychiatric evaluation.On 07/17/25 11:25 am, V2 (Director of Nursing, DON) V2 stated that V2 was not present in the facility during the time of R6 and R7's incident on 07/13/25. V2 stated that V2 was informed by staff that R7 was allegedly seen extending R7's left arm towards R6 during the time of R6 fall on 07/13/25 and that V2 was still

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Based on interview, and record review the facility failed to protect one resident (R6) from physical abuse. This failure affected 1 of 3 residents reviewed for physical abuse and caused R6 to be sent to local hospital and R6 sustaining a comminuted left intertrochanteric fracture requiring R6 to have open reduction internal fixation of the left hip fracture. Findings include: R6 has a diagnosis which include but are not limited to: Repeated falls, Alzheimer's disease, lack of coordination, abnormalities of gait and mobility, weakness, dementia, ataxic gait, unsteadiness on feet, and insomnia. R6 has a Brief Interview for Mental Status (BIMS) dated 07/10/25 with no score and indicates that R6 has memory impairments.R7 has a diagnosis which includes but are not limited to: cocaine abuse, disorientation, other disorders of the brain, cerebral infarction, cerebral ischemia, and anxiety.R7 has a Brief Interview for Mental Status (BIMS) dated 04/30/25 with a score of 6 and indicates that R6 has memory impairments. During this survey R6 was able to answer surveyor questions appropriately.The facility Initial Reportable Incident to the state agency dated 07/13/25 at 9:40 am, documents, in part: R7 allegedly made contact with R6. R6 and R7 immediately separated. Body assessment completed on R7, no injuries or pain. R6 sent to local hospital for an evaluation. Hospital reported R6 sustained left hip fracture due to fall. Physician and family notified. Police was contacted and notified. R7 was placed on one-to-one period. investigation initiated. R6's local hospital record dated 07/14/25 documents, in part: Interval Events: Plan for open reduction internal fixation left hip fracture . Imaging/Other Studies: CT (Computed Tomography) without contrast, left: Results: 07/14/25: Impression: 1: Comminuted left intertrochanteric fracture.On 07/15/25 at 11:30 am, Surveyors observed V23 (Licensed Practical Nurse, LPN) (R6 and R7's nurse on 07/13/25) leave the facility via 911 emergency due to V23 not feeling well. On 07/15/25 at 1:07 pm, V12 (R6's Family Member) stated that on 07/13/25 V12 received a phone call from V23 (LPN) stating that V23 turned away from R6 for one second and R6 was pushed by R7 onto the floor. V12 also explained that V23 informed V12 that R6 was going to the local hospital for an evaluation. V12 stated that the local hospital informed V12 that R6 sustained a left hip fracture. V12 then explained that on 07/14/25 V12 came to the facility and informed V1 (Administrator) at facility that V12 filed a police report number JJ333620 regarding R7 pushing R6 onto the floor causing R6 to sustain a left hip fracture. On 07/16/25 at 9:31 am, V1 (Administrator) informed surveyors that V23 was a admitted to the local hospital. Surveyor was not able to interview V23 for this investigation. On 07/16/25 at 9:52 am, R7 stated that a few days ago R7 was standing at the elevator when R6 kept approaching R7. R7 stated that R7 told R6 Get the F*** away from me and pushed R6 away from R7. R7 explained that R6 landed on the floor after R7 pushed R6. R7 then stated, I didn't throw her down. I pushed her. R7 then reiterated that R7 kept yelling at R6 Stay away from me and that R6 didn't. On 07/16/25 at 10:23 am, V22 (Certified Nursing Assistant, CNA) denied that V22 was assigned to R6 or R7 on 07/13/25 and does not know where V25 (CNA) and V26 (CNA) (who were assigned to R6 and R7) were located on the unit during the time of R6 and R7's incident. V22 explained that V22 believes that V25 and V26 were down the hallway gathering their belongings to leave for the day. V22 further explained that V22 was at the nurse's station on 07/13/25 during the time of the incident with R6 and R7. V22 then stated that V22 recalls R6 standing in front of R7 at the nurse's station, elevator area when R7 was telling R6 to get out of her (R7's) face. V22 further explained that R6 kept walking into R7's face when R7 turned around and put her (R7's) hand out in front of R6 making contact with R6's chest causing R6 to fall onto the floor. V22 further explained that V22 was behind the nurse's station when the incident occurred and was gathering her belongings to go home. V22 then explained that by the time she came from around the nurse's station to R6 and R7, R6 was already on the floor. V22 also explained that V23 (Licensed Practical Nurse, LPN) R6 and R7's assigned nurse was down the third-floor unit hallway still passing medications and that V24 (Registered Nurse, RN) was sitting at the nurse's station charting. V22 explained that V22 and V23 (LPN) assisted R6 off the floor. On 07/17/25 at 9:34 am V24 (Registered Nurse, RN) stated that on 07/13/25 around 6:45 am, V24 was at the nurses station charting and not paying attention to R6 and R7 at the third-floor unit elevator area in front of the nurses station. V24 explained that V22 (CNA) was informed V24 that R6 sustained a fall at the nurses station in front of the elevator. V24 stated that although V24 was at the nurses station with R6 when R6 sustained a fall, V24 denies witnessing or hearing R6 sustained a fall or hear any conversation between R6 and R7. V24 explained that V24 was not the assigned nurse for R7 or R6 and did not assist with R6's fall on 07/13/25. V24 stated that R6 is a resident that ambulates with unsteady gait and requires assistance from staff

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide adequate supervision for a resident (R6) at risk for falls and failed to ensure that a resident (R6) at risk for falls does not have repeated falls. These failures affected 1 of 3 residents, reviewed for falls and fall prevention interventions, caused R6 to be sent to local hospital and R6 sustaining a comminuted left intertrochanteric fracture requiring R6 to have open reduction internal fixation of the left hip fracture.Findings include:R6 has a diagnosis which include but are not limited to: Repeated falls, Alzheimer's disease, lack of coordination, abnormalities of gait and mobility, weakness, dementia, ataxic gait, unsteadiness on feet, and insomnia. R6 has a Brief Interview for Mental Status (BIMS) dated 07/10/25 with no score and indicates that R6 has memory impairments.R6 [NAME] Data Set (MDS) dated [DATE] shows that R6 requires supervision or touching assistance for walking. The facility's document dated 03/26/25 through 07/16/25 and titled Incident by Incident Type show that R6 sustained falls on 05/08/25, 05/20/25, 05/25/25, 05/27/25 and 07/13/25 at the facility.R6 Fall Risk Reviews dated 07/13/25, 06/09/25, 05/27/25, 05/26/25, indicate that R6 is high risk for falls.R6's local hospital record dated 07/14/25 documents, in part: Imaging/Other Studies: CT (Computed Tomography) without contrast, left: Results: 07/14/25: Impression: 1: Comminuted left intertrochanteric fracture.On 07/17/25 at 9:34 am V24 (Registered Nurse, RN) stated that on 07/13/25 around 6:45 am, V24 was at the nurse's station charting and not paying attention to R6 when V24 was informed by V22 (Certified Nursing Assistant, CNA) that R6 sustained a fall at the nurse's station near the elevator. V24 denies witnessing or hearing R6 fall when R6 sustained a fall. V24 stated that although V24 was at the nurse's station with R6 when R6 sustained a fall, V24 was not the assigned nurse for R6 and did not assist with R6's fall on 07/13/25. V24 stated that R6 is a resident that ambulates with unsteady gait and requires assistance from staff supervision when ambulating. V24 explained if a resident who ambulates requires staff supervision is not supervised the resident can sustain a fall, elope, or encounter an argument with another resident. V24 then explained that it is important to monitor residents who walk with an unsteady gait because the resident may need assistance from staff to prevent the resident from falling. On 07/17/25 at 9:48 am V25 (Certified Nurse's Assistant/CNA) stated that on 07/13/25 when R6 sustained a fall, V25 was assigned to R6 and got R6 dressed around 4:30 am and R6 began walking throughout the unit. V25 explained that R6 is a resident who requires supervision from staff when she walks. V25 further explained that V25 is instructed to walk with R6 when she is up walking because R6 is a high risk for falls. V25 explained that during the time of R6's fall on 07/13/25 V25 did not witness R6 fall at the nurse's station near the elevator and that V25 was at the nurse's station packing V25's belongings (cell phone and cell phone charger) preparing to go home. V25 explained that V25 heard a sound and observed R6 laying on the floor in front of the elevator at the nurse's station and R7 standing next to R6. V25 also explained that V23 (Licensed Practical Nurse/LPN) (R6's nurse) was down the third-floor unit hallway preparing her cart/medications when V25 called for V23 to assist after R6's fall. V25 explained that V25 and V23 (Licensed Practical Nurse, LPN) assisted R6 off the floor. On 07/17/25 at 10:00 am, V26 (CNA) stated that V26 did not witness R6 fall on 07/13/25. V26 explained that it was the end of V26's shift and V26 was at the nurse's station charting waiting for the next shift staff to arrive. V26 stated that V26 was not assigned to R6 or R7 on 07/13/25 during the time of R6's fall incident. V26 explained that V22 (CNA) informed V26 that R7 pushed R6. V26 also stated that V26 heard V23 (LPN) stating to R7 Why did you do that to R6. V26 explained that the V23 (LPN), V25, and V22 (who were assigned to R6 and R7) addressed the situation. V26 stated that V26 is familiar and has cared for R6 in the past. V26 stated that R6 ambulates and requires supervision when walking to prevent R6 from falling.On 07/17/25 at 10:35 am V28 (On Call Physician) (R6 physician on 07/13/25, R6 last fall) stated that on 7/13/25 V28 received a call from the facility that staff witness R6 falling backwards onto R6's back area and complained of facial grimaces. V28 explained that staff informed V28 that R6 was a resident who walked with an unsteady gait and was roaming the nurses station area when R6 fell. V28 stated that residents who ambulate with and unsteady gait should be placed in a fall supervision program and supervised by staff at all times when walking to avoid the resident from falling and sustaining an injury. V28 also stated that V28 was informed that R6 ‘s evaluation at the local hospital showed that R6 sustained a hip fracture due to R6 fall on 07/13/25.On 07/17/25 11:25 am, V2 (Director of Nursing, DON) stated that R6 is an alert not alert resident, who wanders throughout the unit, is high risk for falls, has had multiple fall incidents in the past and requires supervision from staff when walking

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure the outgoing nurse signed the First Floor Team II Controlled Substances Check Form. This failure affected 4 (R2, R8, R9, and R10) residents reviewed for controlled medications in the total sample of 10 residents.Findings include: On 07/14/2025 at 11:34am, V6 (Licensed Practice Nurse) stated the First Floor Team II medication cart is for residents from room [ROOM NUMBER] to 118. The (07/14/2025) Daily Roster indicated that R2, R8, R9, and R10 resided in First Floor Team II.On 07/14/2025 at 11:58am, during the medication storage and labeling task with V6 (Licensed Practice Nurse) of the First Floor Team II medication cart, the Controlled Substances Check Form has a missing signature on day 7/11/2025, 3-11 shift, Nurse Off. This was pointed out to V6. V6 stated that nurses are signing the form to document the controlled medications are counted to ensure there are no missing controlled medications.On 07/15/2025 at 11:26am, V2 (Director Of Nursing) stated incoming and outgoing nurses should count the controlled medications during shift change to ensure there are no missing controlled medications. The nurses are expected to sign the Controlled Substances Check Form to document and prove they counted the controlled substances. R2's (Order Date Range: 05/01/2025-07/31/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) abdominal pain, restless leg syndrome, and chronic pain syndrome. Order Summary. Morphine Sulfate solution 20MG/ml, give 0.25ml by mouth every 4 hours. Order Status: Active. Order Date: 05/22/2025. Morphine Sulfate solution 20MG/ml, give 0.5ml by mouth every 4 hours. Order Status: Active. Order Date: 05/22/2025. R8's (Active Order as Of: 07/17/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) chronic pain syndrome, depression, and bariatric surgery status. Order Summary. HYDROcodone-Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Pain. Active 02/06/2025.R9's (Active Order as Of: 07/17/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) anxiety disorder, extrapyramidal and movement disorder, and bipolar disorder. Order Summary. LORazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth two times a day for anxiety. Active: 12/09/2024. R10's (Active Order as Of: 07/17/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) depression, pain, and low back pain. Order Summary. Hydrocodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth every 6 hours as needed for Pain. Active: 05/12/2025.The (undated) Registered Nurse Job Description documented, in part Position Summary: The Registered Nurse provides direct nursing care to the residents and supervises the day-to-day nursing activities performed by nursing assistants. The person holding this position is delegated the administrative authority, responsibility, and accountability for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations and established company policies and procedures to ensure that the highest degree of quality care is maintained at all times. C. Role Responsibilities- Drug Administration: 6. Ensures That narcotic records are accurate for your shift.The (05/2024) Controlled substances documented, in part policy: medications classified by the FDA (food and drug authority) trolled substances have high abuse potential and may be subject to special handling, storage, and record keeping. Procedure: 4. While a controlled substance is in use (,) the nursing staff will maintain the following medication records: b. All schedule II controlled substances (and other schedules if facility policy so dictates) will be counted each shift or whenever there is an exchange of keys between off going and oncoming licensed nurses. 4. Both nurses will sign the shift/shift controlled substance counts sheet acknowledging that the actual count of controlled substances and count sheet matches the quantity documented

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews and record reviews, the facility failed to ensure controlled substance is properly labeled. This failure affected 1 (R2) resident reviewed for labeling of controlled substance in the total sample of 10 residents.Findings include:On 07/14/2025 at 3:34pm, this surveyor requested V6 (Licensed Practice Nurse) to show the label on R2's Morphine Sulfate. R2's Morphine sulfate label on the packages of the medication indicated Take 0.25ml (5mg) for moderate pain or take 0.5ml (10mg) by mouth under the tongue every 1 hour as needed for severe pain. This surveyor requested V6 to check for R2's order of Morphine Sulfate. V6, looking at R2's electronic health record, stated the order is to may give 0.25ml or 0. 5ml every 4 hours. This surveyor requested V6 to check the label on the package of R2's Morphine Sulfate and the actual order for R2's Morphine sulfate. V6 stated the label on the package and the active order for Morphine Sulfate don't match. The expectation is the label on the packaging should match the order for accuracy. On 07/15/2025 at 11:29pm, V2 (Director Of Nursing) stated Hospice, initially, ordered Morphine sulfate to be given every 1 hour, then, I guess the nurse's assessment is the dose is too much if given every 1 hour. The nurse called hospice to change the order to every 4 hours. And when hospice came and do the hospice assessment, they found out every 4 hours as needed is appropriate for her (R2). So, the nurses have been giving her (R2) Morphine every 4 hours as needed. Usually, hospice sends out another bottle with the current order. The expectation is for hospice company to change the label to the current order or send another bottle with a label of the current order to prevent errors in medication administration. R2's (05/23/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 15. Indicating R2's mental status as cognitively intact. R2's (Order Date Range: 05/01/2025-07/31/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) abdominal pain, restless leg syndrome, and chronic pain syndrome. Order Summary. Morphine Sulfate solution 20MG/ml, give 0.25ml by mouth every 1 hour. Order Status: Discontinued. Order Date: 05/22/2025. Morphine Sulfate solution 20MG/ml, give 0.5ml by mouth every 1 hour. Order Status: Discontinued. Order Date: 05/22/2025. Morphine Sulfate solution 20MG/ml, give 0.25ml by mouth every 4 hours. Order Status: Active. Order Date: 05/22/2025. Morphine Sulfate solution 20MG/ml, give 0.5ml by mouth every 4 hours. Order Status: Active. Order Date: 05/22/2025. R2's (05/2025) MAR (Medication Administration Record) documented, in part Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.25 ml by mouth every 1 hours as needed for Pain or SOB -Start Date- 05/22/2025 1329 -D/C (discontinue) Date-05/22/2025 1329. Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.25 ml by mouth every 4 hours s needed for Pain or SOB -Start Date- 05/22/2025 1329. Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.5 ml by mouth every 1 hours as needed for Shortness of Breath or Pain -Start Date-05/22/2025 1346 -D/C Date- 05/22/2025 1346. Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.5 ml by mouth every 4 hours as needed forShortness of Breath or Pain -Start Date- 05/22/2025 1346. The (undated) Prescription Labels documented, in part Policy: Medications are labeled in accordance with state and federal laws as well as facility requirements. Procedure: 2. Improperly labeled medications should be rejected and returned upon delivery. The (undated) Direction/Label Change policy and procedure documented, in part : A registered pharmacist is authorized to make a label change on a medication. The pharmacy will not dispense new labels which are not attached to a product. Procedure: 1. When an existing medication order is changed, the nurse will note the physician's order and update the medication record or treatment record according to facility policy and procedure.5. It is the facility nursing staff's responsibility to inform the pharmacy of these changes. It is imperative that the POS (Physician Order Sheet), the MAR (Medication Administration Record), and prescription label are consistent and uniform.