STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375252	A. Building B. Wing	02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Midwest City Rehabilitation and Nursin	8200 National Avenue Midwest City, OK 73110

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35474 Based on observation, record review, and interview, the facility failed to ensure a homelike environment by maintaining comfortable water temperatures for two (300 hall and 400 hall) of two shower rooms observed for comfortable water temperatures. The maintenance supervisor identified two shower rooms in the facility. Findings: The Water Temperatures, Safety of policy, dated December 2009, read in parts, .Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than ____ [degrees] F ., or the minimum allowable temperature per state regulation .Maintenance staff is responsible for checking thermostats and temperature controls and record the water temperatures in a safety log . On 02/13/24 at 11:09 a.m., Resident #6 stated the water in the shower rooms were hard to adjust. They stated the water was either too hot or too cold. On 02/13/24 at 11:16 a.m., the 300 hall shower room was observed. The shower on the left side was observed to register 84 degrees F with only the hot water running. At 11:18 a.m., the shower on the left side was observed to be 87 degrees F. On 02/13/24 at 11:28 a.m., Resident #4 stated sometimes they had to wait a while for the water to warm up in the 300 hall shower room. They stated the water in the 300 hall shower room was cold but the staff were aware of the concern. Resident #4 stated they did not know what the facility was doing to address the concern. On 02/14/24 at 8:49 a.m., Resident #1 stated they had been choosing bed baths rather than their preferred shower because the water temperature was either hot or cold. They stated there was no in between comfortable temperature. On 02/14/24 at 9:02 a.m., CNA #1 stated the water temperature in the 400 hall shower room would turn cold after a comfortable water temperature was set for the residents. They stated they thought the maintenance supervisor was aware of the issue with inconsistent water temperatures. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/14/24 at 9:25 a.m., CNA #2 stated for the past couple of months they have had to turn both showers on in the 400 hall shower room to maintain comfortable water temperatures. They stated if both showers were not running at the same time the water would go from warm to cold. On 02/14/24 at 9:40 a.m., the 400 hall shower room was observed with the maintenance supervisor. They stated in November 2023 they had replaced a mixing valve but was unaware of any current water temperature concerns. On 02/14/24 at 9:48 a.m., the maintenance supervisor obtained the water temperature in the shower on the right side of the 400 hall shower room. They stated the water temperature was 55 degrees F with only the hot water running. At 9:51 a.m., the maintenance supervisor stated the water temperature in the shower in the right side of the 400 hall shower room had reached 65 degrees F. They stated the left side had the better water temperature but it was registering 65 degrees F as well. On 02/14/24 at 9:53 a.m., the maintenance supervisor stated the shower on the left side was registering 60 degrees F and the shower on the right side registered 122 degrees F. On 02/14/24 at 10:14 a.m. the maintenance supervisor stated they only monitored the water temperature for one shower in each of the two shower rooms. They stated the mixing valves may need to be replaced. On 02/14/24 at 5:36 p.m., the administrator stated the maintenance supervisor monitored water temperatures in the shower rooms to ensure comfortable water temperatures were obtained.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 Based on record review and interview, the facility failed to ensure licensed nurses received competency/skills checks for two (LPN #1 and LPN #3) of five employee files reviewed for competency/skills checks. The DON identified 16 nurses who currently worked at the facility. Findings: 1. LPN #1 was hired on [DATE]. The ODH Form 283, read in parts, .Incident date: [DATE] .Part B .On [DATE] [LPN #1] was the nurse for [Resident #2]. Resident was on hospice and had a physician order for morphone [sic] 0.5ml q4 hours PRN. [LPN #1] stated that [they] administered this medication outside of physician order and time regulations. [LPN #1] stated [they] filled a 10ml syringe with 3ml of morphine and used this to administer several doses to the resident within [their] shift. Resident expired on [DATE]. [LPN #1] was suspended pending the outcome of the investigation .Part C .[LPN #1] was suspended. [LPN #1] will have another nurse sign off on any narcotics given since [they are] not allowed to be terminated. Education was given to the nurses on following physician orders and how to accurately draw medication with a syringe . Review of the employee file for LPN #1 did not reveal a competency/skills check had been completed. 2. LPN #3 was hired [DATE]. Review of the employee file for LPN #3 did not reveal a competency/skills check had been completed. On [DATE] at 8:40 a.m., the DON stated nurses received training and competency/skills checks during orientation and then annually. They stated the competency/skills check should be in the employee file. The DON stated competencies had not been documented for LPN #1 or LPN #3.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35474 Based on observation, record review, and interview, the facility failed to ensure controlled medications were reconciled when they were delivered from the pharmacy for one (#2) of three sampled residents whose medications were reviewed. The DON identified 50 residents had orders for controlled medications. Findings: The Accepting Delivery of Medications policy, dated April 2007, read in parts, .Before signing to accept the delivery, the Nurse must reconcile the medications in the package with the delivery ticket/order receipt .A nurse shall sign the delivery ticket, indicating review and acceptance of the delivery . Resident #2 had diagnoses which included nontraumatic intracerebral hemorrhage. A physician order, dated 01/24/24, documented an order for morphine 20ml/mg every four hours as needed for pain/shortness of breath. A Packing Slip dated 01/24/24, documented the pharmacy had filled 20mls of morphine 20mg/ml for Resident #2. A Prescription History, dated 01/24/24, documented the pharmacy had delivered the morphine to the facility and it had been signed for by LPN #2. The Controlled Drug Receipt/Record/Disposition Form, dated 01/24/24, documented 15mls of morphine 20mg/ml had been received for Resident #2. The ADON signed the form as the nurse receiving the medication. On 02/13/24 at 3:09 p.m., the bottle of morphine 20mg/ml for Resident #2 was observed with the DON. The label indicated the quantity was 20 mls. On 02/14/24 at 10:05 a.m., the ADON stated the nurse had given them the bottle of 15mls of morphine for Resident #2 to lock on the medication cart. They stated they thought the hospice nurse had delivered the medication to the facility. On 02/14/24 at 10:07 a.m., the DON stated once they received medications from pharmacy they documented how much was delivered. They stated they did not compare what the pharmacy documents they sent to what was actually received. They stated they needed to implement a protocol to account for narcotic reconciliation when they were delivered from the pharmacy. On 02/14/24 at 11:56 a.m., LPN #2 stated they had signed for the medication for Resident #2 but they had not verified how much Morphine had been delivered. They stated they had given it to the nurse to be logged and locked up on the medication cart.

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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** 35474 On [DATE] an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to prevent significant medication errors for Resident #2. Resident #2 was ordered Morphine 20mg/ml give 0.5ml every four hours as needed. The Controlled Drug Receipt/Record/Disposition Form, dated [DATE], documented LPN #1 administered Morphine 0.5ml at 6:00 a.m., 10:15 a.m., and 2:30 p.m. The Controlled Drug Receipt/Record/Disposition Form, dated [DATE], documented LPN #1 administered an additional dose of Morphine 0.5ml at 10:15 a.m., 2:30 p.m., and 3:00 p. m. per family request. The MAR, dated [DATE], documented LPN #1 administered Morphine 0.5ml at 5:58 a. m., 11:15 a.m., and 2:23 p.m. On [DATE], LPN #1 stated they had not contacted the physician for orders for the additional doses of Morphine administered to Resident #2. LPN #1 stated the entries on the Controlled Drug Receipt/Record/Disposition Form, dated [DATE], were administered on [DATE] but they had documented the wrong date. Resident #2 expired on [DATE] at 4:13 p.m. On [DATE] at 5:33 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On [DATE] at 5:38 p.m., the administrator was notified of the IJ situation. On [DATE] at 10:14 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented: .Plan of Removal for Immediate Jeopardy February 15, 2024 As requested by state and federal law, the facility, Landmark of Midwest City, is respectfully submitting the following credible allegation of compliance to request removal of the Immediate Jeopardy citation which was issued on February 15, 2024 related to a medication error. Disclaimer Statement: The completion and submission of this credible allegation of compliance does not constitute an admission that the facility agrees with the allegation in the notification of Immediate Jeopardy. The facility is completing the allegation of compliance because it is requested by state and federal law. The facility may disagree with and dispute the alleged deficiency as stated in the Immediate Jeopardy Template. This includes but is not limited to the alleged content, summary, the chronological timing of sequence of events, and the description of care including medication administration to the specified resident. The facility reserves its right to continue disputing, appealing, and contesting this alleged deficiency, and any actions related to and arising therefrom in any forum as needed. According to the Immediate Jeopardy Template, the facility failed to ensure medications were administered as ordered to prevent a significant medication error. Corrective action taken for resident affected by the deficient practice: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse #1 was immediately interviewed and suspended pending investigation on [DATE] following the discovery of the potential medication error, thus removing the potential to affect other residents. Nurse #1 has not worked since [DATE]. Nurse #1 was terminated on [DATE] after not showing up for her scheduled meeting, competency validation, and continued employment evaluation. Resident #2 was receiving hospice care and in the dying process at the time of the potential medication error. Resident #2 passed on [DATE]. How other residents of the facility were identified to potentially be affected: Narcotic count sheets were audited on [DATE] to verify accurate count recorded and matching count of medications. Physician's Ordered were validated to match the Medication Administration Record and administration times were verified to be within acceptable range. What measures were put into place and what systemic changes will be made to ensure the deficient practice does not recur: Licensure verification for licensed nurses and CMA's were completed [DATE]. Licensed Nurses and CMA's were inserviced on medication administration of routine and as needed medication, following physician's orders, physician notification, change of condition, medication orders/requests, additional medication doses, adverse reactions, and new admission process on [DATE]. Phone calls with a verbal inservice will be given if any staff are on vacation of able to come to the facility for an in person inservice. Competency validations began on [DATE] for all licensed nurses and CMA's to be successfully completed prior to administering medication and/or providing care. Newly hired nurses and CMA's will be educated upon hire and competence validated prior to administering medications to any resident. How the corrective actions will be monitored to ensure the deficient practice does not recur: An Ad-Hoc QAPI Meeting was held by the Administrator, the Interdisciplinary Team and Medical Director on [DATE] to review and approved the Plan of Removal and Allegation of Compliance. Audit Tools were created on [DATE] to include monitoring of medication delivery including following physician's orders, narcotic count and accuracy of count compared to actual medication daily for two weeks, weekly for three weeks, and monthly for three months or until substantial compliance is achieved. The QAPI Committee will review the audit tools on a monthly basis and will determine compliance. Any concerns will have been addressed. If indicated, additional Action Plans will be recommended and/or written by the QAPI Committee. All Action Plans will be monitored weekly by the Administrator to ensure substantial compliance. Plan of removal will be completed by [DATE] at 20:00. The IJ was lifted, effective [DATE] at 3:53 p.m., when all components of the plan of removal had been completed. The deficient practice remained as isolated with potential for harm to the residents. Based on observation, record review, and interview, the facility failed to prevent significant medication errors for one (#2) of three sampled residents reviewed for medications administered per physician orders. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON identified 64 residents who were ordered medications in the facility. Findings: A Medication Error policy, dated [DATE], read in parts, .The facility strives to ensure that residents .will not . have their health and safety placed in jeopardy due to a medication error .Procedure .Administer medications within prescribed time frames .Administer medications according to the frequency, route, and dose prescribed . A Guidelines for Physician Orders policy, dated [DATE], read in parts, .It is the policy of the facility to follow the orders of the physician .All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received . Resident #2 had diagnoses which included nontraumatic intracerebral hemorrhage. A physician order, dated [DATE], documented Resident #2 was ordered lorazepam 2mg/ml give one milliliter every four hours as needed for anxiety. An Order Note, dated [DATE] at 4:26 p.m., documented a new order from hospice had been received for morphine 20mg/ml every four hours as needed for pain/shortness of breath. The Controlled Drug Receipt/Record/Disposition Form, documented on [DATE], LPN #1 administered morphine 0.5ml at 6:00 a.m., 10:15 a.m., and 2:30 p.m. The Controlled Drug Receipt/Record/Disposition Form, dated [DATE], documented LPN #1 administered an additional dose of morphine 0.5ml at 10:15 a.m., 2:30 p.m., and 3:00 p.m. per family request. The form documented 13.5ml of morphine, was in the bottle, before the 6:00 a.m. dose was administered by LPN #1. The entry at 3:00 p.m. documented 8ml Morphine, remained in the bottle, after the 3:00 p.m. dose was administered by LPN #1. The MAR, dated [DATE], did not contain documentation morphine 20mg/ml give 0.5ml every four hours had been administered to Resident #2 on [DATE]. The MAR documented Resident #2 had been administered morphine 0.5ml on [DATE] at 5:58 a.m., 11:15 a.m., and 2:23 p.m. by LPN #1. A Medication Administration Note, dated [DATE] at 5:58 a.m., documented the family for Resident #2 was concerned the resident was hurting and starting to stress. The note documented LPN #1 administered Morphine 0.5ml po to Resident #2. A Medication Administration Note, dated [DATE] at 5:59 a.m., documented the family for Resident #2 was concerned the resident was starting to hurt and get stressed because of increased respirations. The note documented LPN #1 administered lorazepam 1ml po to Resident #2. A Medication Administration Note, dated [DATE] at 11:15 a.m., documented LPN #1 administered lorazepam 1ml po and morphine 0.5ml po to Resident #2. A Medication Administration Note, dated [DATE] at 2:23 p.m., doucmented LPN #1 administered lorazepam 1ml po and morphine 0.5ml po to Resident #2. These medications were administered three hours and eight minutes after the last documented doses on the MAR at 11:15 a.m. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Medication Administration Note, dated [DATE] at 4:22 p.m., documented Resident #2 was without heart sounds, respirations and pulse at 4:13 p.m. The ODH Form 283, read in parts, .Incident date: [DATE] .Part B .On [DATE] [LPN #1] was the nurse for [Resident #2]. Resident was on hospice and had a physician order for morphone [sic] 0.5ml q4 hours PRN. [LPN #1] stated that [they] administered this medication outside of physician order and time regulations. [LPN #1] stated [they] filled a 10ml syringe with 3ml of morphine and used this to administer several doses to the resident within [their] shift. Resident expired on [DATE]. [LPN #1] was suspended pending the outcome of the investigation .Part C .[LPN #1] was suspended. [LPN #1] will have another nurse sign off on any narcotics given since [they are] not allowed to be terminated. Education was given to the nurses on following physician orders and how to accurately draw medication with a syringe . (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A written statement by LPN #1, dated [DATE], read in parts, .concerning the scribbled on in-haste morphine count sheet containing liquid morphine prescribed for [Resident #2] .There are missing entries for [DATE] per the ,d+[DATE] shift and entries missing for the [DATE]th 2024 ,d+[DATE] shift. The ledgers were made in haste without thinking. At the time those scribbles were written in I had a family emergency and was unable to think clearly for all the nonsense I was writing in order to take responsibility for the discrepancy. I had thought to appease the oncoming nurse to show in good faith I had entries I needed to justify so that [they] would take the cart keys at that time. We noted the amount of 8ml left in the bottle at that time [at] [DATE] 2222 [10:22 p.m.] .Several days later in attempts to explain my weekend, especially, the events of [Resident #2] actually actively dying .[Resident #2] was noted to be mottled and [their] respirations presented as Cheyne-Stokes at approx 1500 [3:00 p.m.] and the wife and daughter of the actively dying patient became more distraught with anxiety and grief. I had noticed in my attempts to relieve their anxiety and comfort them I assisted with the patients comfort medication morphine; it was at that time 1500 [3:00 p.m.] I noticed the 1ml syringe was not to be found .I sought to find a substitute syringe from the treatment cart. There were several 3ml syringes .I removed the needle from one of the sterile packages, poured morphine into a med cup and drew up approx ,d+[DATE] of the syringe or less of the morphine; located a blue huer cap to secure the morphine from leaking and went to the .bedside. It might be good here to note that every dose of morphine expressed into [Resident #2's] mouth would immediately drool out of [their] mouth onto [their] beard and this had made the daughter [name withheld] question if [they] actually got any of the medicine . with the 10:00 [10:00 a.m.] dose and the 1400 [2:00 p.m.] doses .When the breathing pattern would return to a more slowed pace I would return to the med/treatment cart and lock up the syringe with morphine. Just about every 15 minutes a family member or a friend would find me on the hall .I would stop what I was doing; unlock the syringe of morphine educating the family that I have only an order for every 4 hours with the comfort meds and that only the hospice nurse can redirect the administration. At 1550 [3:50 p.m.] the resident dying hospice pt was noted increasingly blue mottled and with gasping type Kussmual breaths or Cheyne-Stokes .I had educated the family that [they were] actively leaving us and not much else I can do at this time. Placing a very small amount of the morphine onto [Resident #2's] lip crease cheek area to comfort more the family. This would stay drying on [their] mouth and beard and family would wipe [their] mouth with tissue .At approx 1605 [4:05 p.m.] a man rushes up to me .and states 'he has stopped breathing' .I was unable to detect an apical heartbeat. No pulse was noted. No respirations were noted .Into the 2100 [9:00 p. m.] hour I had not even thought about the morphine at all and it wasn't clear the syringe of wasted morphine . the oncoming nurse and myself witnessed that there was a discrepancy from the 12.0 ml to the 8.0 ml. It was at this sense of urgency that I told [them] I take full responsibility attempting to fill in accurate times with the majority missing and unsure how to chart the wasted amounts, I nonsensically scribbled in numbers, squeezed in numbers and scribbled family request at bedside and whatever else with my signature so that oncoming nurse can be held at no fault with the discrepancy. 8ml was in the bottle [at] that date [DATE] 2222 [10:22 p.m.] .I attempted to correct my scribbles on the legal document and justify my actions, the entries and the waste asking for assistance in charting and learning protocol with the charting .I was not allowed the original legal document and was asked to write out my best recollection after attempting to explain in a phoned meeting all together unsure . On [DATE] at 3:09 p.m., the bottle of morphine 20mg/ml for Resident #2 was observed with the DON to have 8mls remaining in the bottle. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:10 p.m., the DON stated LPN #1 reported to them, the regional nurse, and the ADON they had thrown the original dosing syringe away, utilized a 10ml syringe, drew up an unknown amount of morphine to administer to Resident #2 in an attempt to appease the family. The DON stated LPN #1 reported they had added entries to the narcotic record so the oncoming nurse would take the keys. The DON stated they had interviewed LPN #1 three times and each time LPN #1 stated they utilized a 10ml syringe after the dosing syringe had been lost but documented a 3ml syringe on their written statement. The DON stated they suspended LPN #1 pending investigation. They stated they wanted to terminate LPN #1 but had been told corporate would not allow them to terminate LPN #1. The DON stated they felt LPN #1 was a danger to the residents because they had not followed physician orders and did not know how much morphine they had administered to Resdient #2. On [DATE] at 12:34 p.m., the administrator stated LPN #1 reported to them after the original dosing syringe was lost for the Morphine for Resident #2 they drew up 3ml of morphine into a 10ml syringe and utilized that to administer as needed doses on [DATE]. They stated LPN #1 had to have another nurse co-sign any narcotic administration when they returned to work. They stated LPN #1 would have access to narcotic medications so they did not know how that intervention would protect the residents. On [DATE] at 1:23 p.m., the medical director stated LPN #1 had not followed physician orders for morphine for Resident #2. They stated it was gross negligence. The medical director stated Resident #2 was an end of life resident but administering medications outside of physician orders should have never happened. On [DATE] at 2:17 p.m., Regional nurse consultant #1 stated LPN #1 reported to them they had lost the dosing syringe for the morphine for Resident #2. They stated LPN #1 reported they had obtained a 3ml, 5ml, or 10ml syringe, drew up 3mls of Morphine, and administered Morphine from it to Resident #2 when the family requested it. Regional nurse consultant #1 stated LPN #1 reported to them that they would squirt the morphine in the resident's mouth, it would run out, the family would ask for more to be administered and LPN #1 would squirt more in the resident's mouth. Regional nurse consultant #1 stated LPN #1 was an active employee but was suspended pending investigation.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35474 Based on record review and interview, the facility failed to ensure records were accurate for one (#2) of five sampled residents whose records were reviewed. The DON identified 64 residents resided in the facilty. Findings: Resident #2 had diagnoses which included nontraumatic intracerebral hemorrhage. A physician order, dated [DATE], documented Resident #2 was ordered lorazepam 2mg/ml give one milliliter every four hours as needed for anxiety. An Order Note, dated [DATE] at 4:26 p.m., documented a new order from hospice had been received for morphine 20ml/mg every four hours as needed for pain/shortness of breath. The Controlled Drug Receipt/Record/Disposition Form, documented on [DATE], LPN #1 administered morphine 0.5ml at 6:00 a.m., 10:15 a.m., and 2:30 p.m. The Controlled Drug Receipt/Record/Disposition Form, dated [DATE], documented LPN #1 administered an additional dose of morphine 0.5ml at 10:15 a.m., 2:30 p.m., and 3:00 p.m. per family request. The MAR, dated [DATE], did not contain documentation morphine 20mg/ml give 0.5ml every four hours had been administered to Resident #2 on [DATE]. The MAR documented Resident #2 had been administered morphine 0.5ml on [DATE] at 5:58 a.m. with a pain rating of five, 11:15 a.m. with a pain rating of seven, and 2:23 p.m. with a pain rating of four by LPN #1. The MAR documented Resident #2 had lorazepam 2mg/ml - give 1ml ordered daily at 5:00 p.m. and 10:00 p.m. The Medication Administration Note, dated [DATE] at 4:22 p.m., documented the Resident #2 was without heart sounds, respirations, and pulse at 4:13 p.m. The note read in part .LORazepam Oral Concentrate 2 MG/ML Give 1 ml by mouth one time a day for Anxiety . The Medication Administration Note, dated [DATE] at 8:35 p.m., read in part, .LORazepam Oral Concentrate 2 MG/ML Give 1 ml by mouth one time a day for Anxiety . On [DATE] at 11:19 a.m., LPN #1 stated the entries on the Controlled Drug Receipt/Record/Disposition Form that were dated [DATE] were supposed to have been dated [DATE]. They stated they had administered two to three 0.5ml doses of morphine on [DATE] but had not had a chance to document it. On [DATE] at 12:10 p.m., the DON stated LPN #1 documented a dose of lorazepam had been administered to Resident #2 after they had expired. The DON stated LPN #1 had reported to them it was a late entry. The DON stated the electronic health record would not allow a nurse to document a medication was administered unless it was due. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375252	A. Building B. Wing	02/21/2024

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:12 p.m., the DON stated when a pain medication was administered the electronic health record indicated a pain level needed to be documented. The DON stated they did not know how a pain rating had been determined for Resident #2 on [DATE] because LPN #1 had reported to them the resident was out of it when the doses of morphine were administered. The DON stated they reviewed a 24 hour report to monitor for complete and accurate clinical records and would ask the nurses for clarification if needed.