

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375385	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER Parkland Manor Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 922 West Parkland Avenue Prague, OK 74864	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>35389</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <p>a. medications were administered as ordered for one (#2);</p> <p>b. an accurate account of controlled medications was maintained for two (#2 and #4); and</p> <p>c. a physician ordered medication was available to administer for one (#4) of three sampled residents reviewed for pain.</p> <p>The BOM identified 17 residents with orders for pain medication resided in the facility.</p> <p>Findings:</p> <p>An undated Medication Handling Procedure policy, read in part, .The facility staff is responsible for reordering the medication when needed .The Refill Order Form serves as the system's basic form to facilitate the transfer of medication reorders .</p> <p>An undated Storage and Documentation of Controlled Medications policy, read in part, .All controlled medications shall be checked for accountability at each change of shift .In the event that a discrepancy is noted follow the policy with regard to pilferage .</p> <p>An undated Medication Discrepancies policy, read in part, .When a discrepancy is noted in controlled medication during shift count the off going nurse will investigate the possible reason for the discrepancy .If the discrepancy cannot be found the Director of Nurses is to be notified immediately and an incident report will be filled out, stating the facts and signed by both the off going and oncoming nurses. The Director of Nurses will then notify the</p> <p>Administrator and a formal in house investigation initiated. The Director of Nursing is to monitor closely for any forming discrepancy patterns and the consultation pharmacist notified .</p> <p>1. Resident #2 had diagnoses which included DIC, pneumonia, and sepsis.</p> <p>Physician orders, dated 08/21/24, documented hydromorphone (pain medication) one mg/ml po q four hours prn; and Ativan (lorazepam) (benzodiazepine) 0.5 mg liquid by mouth q four hours prn.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Physician Order, dated 08/22 (the order did not contain the year), documented clarification order hydromorphone one mg/ml give one ml sublingual every four hours routine for pain relief/air hunger.</p> <p>A Physician order, dated 08/22/24, documented change prn lorazepam to routine lorazepam two mg/ml give 0.5 ml sublingual q four hours. It documented may give with the routine hydromorphone.</p> <p>The count sheet for Resident #2's lorazepam two mg/ml documented give 0.5 ml po (the PRN was marked out) q four hours for anxiety and agitation routine every four hours. It documented the last dose was administered on 08/23/24 at 10:00 p.m. with a remaining count of 13.5 ml. Under this it documented, count corrected, dated 08/23/24 at 11:30 p.m. with an 11 written beside it. There was another time entered under that with the time 11:26 p.m. The bottom of the count sheet documented can not count correct without another nurse or DON to witness.</p> <p>The count sheet for Resident #2's hydromorphone one mg/ml give one ml po prn q four hours for pain relief and air hunger. Under this line it documented not a prn order. It documented one dose was administered on 08/23/24 at 8:00 p.m. with a remaining count of 12. Under this it was documented count corrected 08/23/24 at 11:30 p.m. with a count of 15. It documented times of 2:00 a.m. and 6:00 a.m. with no amount administered. It documented the last dose was administered 08/24/24 at 10:00 a.m. with a remaining count of 14 ml. The bottom of the form documented can not count correct without another nurse or DON to witness and cannot scribble on any legal form.</p> <p>The August 2024 medication administration record did not document Resident #2's routine lorazepam or routine hydromorphone was administered on 08/24/24 at 2:00 a.m. or 6:00 a.m. It documented the routine lorazepam was administered on 08/24/24 at 10:00 a.m. and 2:00 p.m. Neither of these administrations were signed out on the count sheet. It documented the routine hydromorphone was administered on 08/24/24 at 2:00 p.m. This administration was not signed out on the count sheet.</p> <p>A Nurse Note, dated 08/24/24 at 3:36 p.m., documented Resident #2 was given the last dose of medications at 2:30 p.m.</p> <p>A Quality Assurance meeting, dated 09/06/24, documented the issues were scribbling on narc count sheet; count correcting; hospice med changes. It documented the following resolutions:</p> <ul style="list-style-type: none"> a. monitor residents that were pulled by the state during complaint survey over issue; b. switch out bottles to syringes as they needed refilled; and c. DON or assignee to monitor and report findings during monthly QA. <p>An in-service, dated 09/06/24, read in part, .All medications for [unknown resident] and [Resident #4] will be signed out and administered by a nurse & Med Aide and the MAR/TAR & Narcotic Records documented by both .</p> <p>An in-service, dated 09/11/24, documented scribbling-one line errors, no MAR/TAR or narc form would be scribbled on. It documented narcotic forms, a prn order would have its own form separate from a routine form. It documented when nurses began to run low on an item used for treatment or medication administration, they were to inform the CMA or the nurse to notify pharmacy provider.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Neither in-service addressed an accurate account of controlled medications or what to do when a count sheet was inaccurate.</p> <p>On 10/30/24 at 11:30 a.m., Family Member #1 stated the facility would not take the pain medications the hospice had for Resident #2. They stated Resident #2 laid in pain for four and a half hours. They stated the facility used a pharmacy out of Ardmore and would not use the pain medicine hospice had. They stated the facility did get the same medication in that hospice had for Resident #2.</p> <p>On 11/01/24 at 10:22 a.m., the DON stated they had in-serviced staff on the need to document everything that happened on a count sheet. They stated staff were in-serviced that they were not permitted to correct a count alone.</p> <p>On 11/01/24 at 10:24 a.m., the DON stated prn medications were to have a separate count sheet than the routine medication. They stated sometimes liquid morphine could leak. They stated staff were to get the DON immediately if this happened. The DON stated the facility had requested for pharmacy to send syringes to better visualize the amount. They stated staff were to verify the label and if there were any discrepancies, they were to go to the DON to review the order and pharmacy label. They stated hospice had also been instructed they were not to make medication changes without speaking to the DON to ensure there was no confusion.</p> <p>On 11/01/24 at 10:25 a.m., the DON stated Resident #2's hydromorphone was not a prn order. They stated the resident had a prn order and then routine. The DON stated on the count sheet where it documented 08/23/24 and 15, LPN #1 was scribbling. The DON stated they had an in-service and went over that it was not legal or appropriate documentation. The DON stated when they went in the count was three ml over. They stated they would say the resident probably did not get their medication as ordered. The DON stated LPN #1 was written up and no longer worked at the facility. They stated the facility implemented two signatures were required when administering these types of medication and LPN #1 still did it alone.</p> <p>On 11/01/24 at 10:30 a.m., the DON stated LPN #1 was the person who documented the count of lorazepam going from 13.5 ml to 11 ml. They stated the count should have been 13. The DON stated the count sheet did not document the medication was administered as ordered.</p> <p>On 11/01/24 at 12:18 p.m., the DON stated Resident #2 was not included on the in-service dated 09/06/24. They stated the count sheets the surveyor had was the end for Resident #2's controlled medications. They stated they would look to see the reason the scheduled lorazepam was not administered. They stated they QA'd after this and they would provide the copies.</p> <p>On 11/01/24 at 1:45 p.m., the DON stated Resident #2's medication was not administered as ordered on 08/24/24 at 2:00 a.m. and 6:00 a.m.</p> <p>2. Resident #4 had diagnoses which included multiple sclerosis and trigeminal neuralgia.</p> <p>A Physician Order, dated 07/24/24, documented morphine 100 mg/5 ml give 0.5 ml sublingually every two hours prn for pain/shortness of breath.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #4's count sheet, date received 08/21/24, documented morphine sulfate 100 mg/5 ml give 0.5 ml by mouth every four hours prn. It documented the count on 10/07/24 at 5:00 a.m. was 4 ml. It documented count correction on the next dose administered on 10/07/24 at 8:00 a.m. with an amount remaining of zero.</p> <p>A Physician Order, dated 08/31/24, documented morphine 100 mg/5 ml place and dissolve 0.5 ml sublingually every four hours for trigeminal neuralgia.</p> <p>Physician Orders, dated 10/08/24, documented clarification on morphine order, continue morphine sulfate 100 mg/5 ml give 0.5 ml sublingual every two hours prn for break through pain individual syringes, and morphine sulfate 100 mg/5 ml give 0.5 ml sublingual every four hours routinely for trigeminal neuralgia individual syringes.</p> <p>Resident #4's count sheet, received 10/21/24, documented morphine 100 mg/5 ml give 0.5 ml every two hours prn. It documented the last dose was administered on 10/25/24 at 6:15 p.m. with zero count remaining.</p> <p>On 11/01/24 at 10:35 a.m., CNA #1 stated if a resident experienced signs and symptoms of pain, they would notify the nurse and medication aide. They stated they would see if there was anything they could do to improve their comfort.</p> <p>On 11/01/24 at 10:40 a.m., LPN #2 stated when a resident experienced pain, they would ask the location and have the resident rate their pain if able. They stated if the pain was high enough, they would ask the resident if they wanted a pain medication and try non pharmacological interventions first to see if it helped.</p> <p>On 11/01/24 at 10:45 a.m., LPN #2 stated staff were to check medications three times before administering and verify all the rights. They stated if a resident refused a medication, they would ask the reason and explain any questions the resident had.</p> <p>On 11/01/24 at 1:30 p.m., LPN #2 was asked to explain Resident #4's morphine count sheet that went from a count of four to zero on 10/07/24. They stated with bottles, when staff tipped it over, it leaked. They stated the facility no longer did bottles only syringes. They stated when it leaked, and the count was off, they had to do a count correction. They stated when staff gave the last dose on 10/07/24 at 8:00 a.m. there was only 0.5 left in the bottle and then the count was zero.</p> <p>On 11/01/24 at 1:33 p.m., LPN #2 was asked to verify Resident #4's morphine count on the medication cart. There was no prn morphine available in the medication cart for Resident #4. The administrator walked by and stated they would look for it.</p> <p>On 11/01/24 at 1:40 p.m., the DON stated Resident #4's morphine that went from a count of four to zero was a bottle with a dropper. They stated it was leaking out because the bottle was sticky. They stated the facility was changing to syringes. The administrator stated, We started in September. The DON stated sometimes they were overfilled. The administrator stated, You can say they are 5 ml, but you look and they are not.</p> <p>On 11/01/24 at 1:50 p.m., the DON stated Resident #4's prn morphine was Not here.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/01/24 at 1:51 p.m., CMA #1 stated staff went through medications, if they were not available, staff would go check the medication storage room. They stated if the medication was not available there, they would call pharmacy and make sure they received it in the building the same day. They stated they ordered Mondays, Wednesdays, and Fridays. They stated on Tuesday and Thursday they completed a heavy narcotic order. CMA #1 stated they were not aware of Resident #4's prn morphine being out. They stated they would have called pharmacy and if pharmacy could not get it, they would have notified hospice.</p> <p>On 11/01/24 at 1:55 p.m., LPN #2 stated they believed the policy for ensuring medications were available to administer was to order seven days in advance to ensure there was a week of pills available.</p>		