STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375415	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Manor	226 E Monroe Street Jay, OK 74346

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, record review, and interview, the facility failed to: a. ensure a chemical restraint was not used to prevent a resident from eloping from the facility for 1 (#21) of 2 sampled residents reviewed for abuse; and b. ensure an as needed antianxiety medication order was limited to 14 days for 1 (#28) of 5 sampled resident reviewed for unnecessary medication.The administrator identified seven residents had been assessed at risk for wandering and elopement and two residents as a high risk for wandering and elopement. The DON identified two residents were prescribed PRN antianxiety medications.Findings:1. A video recording of the dining room, dated 05/31/26 at 4:37 p.m. through 05/31/26 at 4:42 p.m., showed the following:a. At one minute and 18 seconds into the video recording, the video showed Resident #21 walking through the dining area when LPN #1 stepped in front of the resident causing them to stop;b. At one minute and 23 seconds, the video recording showed CMA #1 standing in front of Resident #21 blocking their movement around LPN #1;c. At one minute and 30 seconds, the video recording showed LPN #1 direct Resident #21 to sit in a chair located at a dining table;d. At one minute and 52 seconds, the video recording showed Resident #21 sitting in the chair at the dining table;e. At four minutes and 42 seconds, the video recording showed Resident #21, sitting in the same chair at the dining table with LPN #1 located behind them. The video recording showed LPN #1 leaning toward Resident #21 and holding the resident's left arm with their left hand;f. At four minutes and 50 seconds, the video recording showed CMA #1 standing to the right of the sitting Resident #21. The video recording showed CMA #1 bent down and leaned toward the resident while LPN #1 continued to be leaned over the back of Resident #21 (refer to CMA #1 and LPN #1 interviews for their admission to the medication administration at this point in the video recording);g. At four minutes and 57 seconds, the video recording showed CMA #1 abruptly stand upright and move back from Resident #21; andh. At four minutes and 59 seconds, the video recording ended.An undated policy titled Restraint and Side Rail Documentation Policy, read in part, No resident will be restrained for staff convenience or for any type of discipline.The resident has the right to be free from any physical or chemical restraints imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms.A physician order for Resident #21, dated 12/30/25, showed the resident was to be administered 0.25 ml of morphine sulfate (an opioid pain medication) concentrate solution 20 mg/ml every four hours as needed for pain.An admission assessment, dated 01/11/26, showed Resident #21 had a BIMS score of 5 (a BIMS score of 5 indicated the resident's cognition was severely impaired) and diagnoses which included Alzheimer's Disease.An initial incident report, incident date 05/31/26, showed the administrator had been informed by an unidentified resident that Resident #21 had been forced to take medication. The incident report showed the administrator reviewed available facility camera footage and observed LPN 1 and CMA #1 administer Resident #21 medication. The incident report showed the administrator suspended LPN #1 and CMA #1 pending an investigation. The incident report showed the administrator reported the incident to the Oklahoma State Department of Health on 06/04/26.On 06/17/26 at 10:20 a.m., LPN #1 stated on 05/31/26, Resident #21 had been agitated and attempting to elope from the facility for about one to one and a half hours. LPN #1 stated Resident #21 continued (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to be agitated and attempting to elope and the evening meal service was set to begin. LPN #1 stated they knew it was time they needed to try something else to end Resident #21's elopement seeking behavior. LPN #1 stated they went to CMA #1 and asked if Resident #21 had a PRN medication that could be administered to the resident. LPN #1 stated CMA #1 reviewed Resident 21's medication list and found the resident had PRN morphine ordered for pain. LPN #1 stated they had thought the resident could have been in pain and they chose to administer the morphine. LPN #1 stated they informed CMA #1 to prepare a syringe with morphine and attempted to administer it to Resident #21. LPN #1 stated Resident #21 physically resisted taking the medication and knocked the syringe with morphine out of their hand causing them to throw away the dose. LPN #1 stated they instructed CMA #1 to administer a second syringe of morphine to Resident #21. LPN #1 stated they were able to get some of the medication into the mouth of Resident #21 but were uncertain how much. LPN #1 stated Resident #21 sat in the common area for about 20 minutes following the second attempt to administer the morphine then went to their room and laid down on their bed.On 06/17/26 at 12:17 p.m., CNA #3 stated they had witnessed Resident #21 being forced to take medication they did not want on 05/31/26. CNA #3 stated Resident #21 had been trying to elope from the facility for about one hour. They stated they also observed CMA #1 attempt to administer a syringe of morphine into the mouth of Resident #21 while the resident was speaking. CNA #3 stated Resident #21 knocked the syringe to the floor. CNA #3 stated Resident #21 had repeatedly told CNA #1 and LPN #1 they did not want to take the medication because it was poison. CNA #3 stated they had asked if they could call a family member for Resident #21 to see if they could calm the resident. CNA #3 stated LPN #1 had stated there was no one to call. CNA #3 stated they left the area at that time and did not know if a second syringe was administered.On 06/17/26 at 12:31 p.m., CNA #4 stated they had observed CMA #1 try to administer a syringe of medication to Resident #21 on 05/31/26. CNA #4 stated Resident #21 had blocked the medication from the syringe, and it sprayed onto the floor. CNA #4 stated they observed CMA #1 and LPN #1 leave the area after attempting to administer the medication and return with another syringe. CNA #4 stated they did not witness the second attempt to medicate Resident #21.On 06/17/26 at 12:40 p.m., CNA #5 stated Resident #21 was upset and attempted to leave the facility on 05/31/26. CNA #5 stated they observed LPN #1 hold Resident #21 down in a chair in the dining room. CNA #5 stated LPN #1 would not allow Resident #21 to get up from the chair and a CMA administered medication to Resident #21. CNA #5 was unable to recall the name of the CMA. CNA #5 stated prior to being administered the medication, Resident #21 had repeatedly told LPN #1 and the CMA #1 that they did not want to take the medication because it was poison.On 06/22/26 at 10:09 a.m., the DON viewed the facility video footage of the incident on 05/31/26 where LPN #1 and CMA #1 had attempted to administer medication to Resident #21 in the dining area. The DON identified LPN #1 as the person standing behind the sitting Resident #21 and CMA #1 as the person standing to the right of Resident #21 who appeared to be attempting to administer medication to the resident.On 06/22/26 at 10:20 a.m., the DON stated the video they had observed with the surveyor was of the second and final attempt by LPN #1 and CMA #1 to administer morphine to Resident #21.On 06/22/26 at 10:46 a.m., CMA #1 stated they were approached by LPN #1 who stated Resident #21 needed something to calm them down. CMA #1 stated they informed LPN #1 that Resident #21's anxiety medication was ordered for specific times and could not be administered at that time. CMA #1 stated LPN #1 asked if there were any other PRN medications and they replied, Resident #21 had PRN morphine ordered for pain. CMA #1 stated LPN #1 informed them to prepare the morphine which they did. CMA #1 stated they prepared a syringe with the morphine and attempted to administer it to Resident #21. CMA #1 stated Resident #21 was able to squeeze the medication out of the syringe before getting any in their mouth. CMA #1 stated LPN #1 instructed them to prepare another dose of morphine and suggested they place the medication in a medication cup. CMA #1 stated they went to the dining room, and while Resident #21 was sitting on a dining room chair, LPN #1 went behind the resident, and they stood to the right of the resident. CMA #1 stated LPN #1 asked them to hold the right hand of Resident #21, and they (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed LPN #1 hold the left hand of Resident #21. CMA #1 stated they observed LPN #1 attempt to pour the medication into Resident #21's mouth. CMA #1 stated Resident #21 had their mouth shut tight and they did not know if any medication entered the resident's mouth. CMA #1 stated they did not make any further attempts to medicate Resident #21 because the resident calmed down and went to their room a little while later.On 06/22/26 at 11:22 a.m., LPN #1 stated they had been the person who administered the second dose of morphine to Resident #21 on 05/31/26. LPN #1 stated the only time they held Resident #21's arms was when the resident attempted to hit them.On 06/23/26 at 12:10 p.m., the administrator stated the staff had not followed facility procedures when they had not recognized and reported Resident #21 had been administered medication against their will.2. A facility policy titled Psychotropic Medication Management Policy (Routine and PRN), dated 08/20/25, read in part, PRN psychotropic medication orders are limited to fourteen (14) days. PRN orders shall not continue beyond fourteen days unless attending physician or prescribing practitioner documents the clinical rationale for extending the order and specifies the duration of the extension. Automatic renewal of PRN psychotropic medication orders is prohibited.A physician order for Resident #28, dated 10/06/25, showed the resident was prescribed Ativan (a medication to treat anxiety) 1 mg every six hours as needed for anxiety. The order showed the PRN Ativan was to be renewed after 60 days.A quarterly assessment for Resident #28, dated 05/11/26, showed the resident had a BIMS score of 15 (a BIMS score of 15 indicated the resident's cognition was not impaired) and they had diagnoses which included dementia and anxiety.A medication administration record for Resident #28, dated 06/01/26 through 06/30/26, showed Resident #28 had an order for Ativan 1 mg PRN that could be administered every six hours for anxiety. The Ativan order had a start date of 10/06/25. The medication administration record showed Resident #28 was administered Ativan on 06/02/26 at 3:10 a.m., 06/13/26 at 5:16 a.m., 06/13/26 at 3:59 p.m., and 06/14/26 at 11:45 a.m.On 06/15/26 at 2:21 p.m. the DON stated Resident #28 received Ativan because the resident would become anxious which caused shortness of breath. The DON stated the pharmacy usually identified issues with PRN antianxiety medication discontinue dates. The DON stated in the case of Resident #28's Ativan order not being limited to 14 days, they could not find any documentation the pharmacy had notified the physician about the problem.