STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675093	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Rehabilitation and Care Center	4306 24th St Lubbock, TX 79410

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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 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** 43344 Based on interviews, and record review, the facility failed to ensure each resident drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 5 residents (Resident #1) reviewed for pharmacy services. A. The facility failed to monitor, review, and reconcile Resident #1's medication administration record from April 2024- October 2024. This failure placed residents at risk for not receiving prescribed medications and drug diversion. Findings included: Record review of Resident #1's face sheet, dated 10/17/24, reflected a [AGE] year-old, who was admitted to the facility on [DATE]. He was diagnosed with Dementia (the loss of cognitive functioning), Alzheimer's disease (memory loss), and altered mental status. Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: *Section C Brief Interview for Mental Status score revealed a score of 02, which indicated the resident's cognition was severely impaired. *Section B0800. Ability to understand others, Resident #1 had unclear speech, rarely/never could himself understood and rarely understood others. *Section N- Medications. Indicated that Resident #1 took antidepressants but no other high-risk medications in any other drug class. (N0415). Record review of Resident #1's care plan, dated 7/14/22, reflected the following: Aa focused area, initiated on 7/14/2022, Resident #1 was on pain medication therapy r/t disease process (takes morphine and Tylenol 325 MG). The goal initiated on 7/14/2022, was that Resident #1 will be free of any discomfort or adverse side effects from pain or medication through the review date. The Intervention initiated 7/14/2022, was that staff was supposed to administer medications as ordered. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Order Summary Report, viewed on 10/17/2024, reflected the resident was ordered morphine sulfate 100 Mg/5 ML and was to be given .25 ML by mouth or sublingual every 4 hours as needed or as directed for pain or air hunger; Ordered 06/13/2024. Record review of the medication administration log for Resident #1 from the pharmacy revealed the following: LVN A received the morphine (undated) and it contained 30 ML LVN B administered the medication at the dose of .25 ML on 06/17/24 (29.75 ML), 06/21/24 (29.50 ML), 06/23/24 (29.25 ML), and 06/26/24 (29 ML). LVN A administered the medication at the dose of .25 ML on 06/30/24 (28.75 ML). LVN B administered the medication at the dose of .25 ML on 07/7/24 (28.5 ML), 07/21/24 (28.25 ML) and 07/26/24 (28 ML). LVN C administered the medication at the dose of .25 ML on 10/09/24 (27.75 ML). Record review of the medication administration log for Resident #1 from the EMR revealed the following: LVN B administered the medication at the dose of .25 ML on 06/21/24, 06/22/24, 7/08/24 and 07/26/24. Record review of a picture of Resident #1's morphine dated 10/10/24 revealed the following: A black and white photo of the Resident #1 morphine box handwritten that the bottle was received 4/17/24. A black and white photo of the morphine bottle with partial of Resident #1's name shown. The liquid in the bottle is right under the 20 ML mark. Handwritten reflect that the liquid should have been under the 28 ML. Record review of Resident #1's pain level summary report undated revealed the following pain values on the coinciding days the liquid morphine was administered: 06/17/24: LVN B documented a pain level of 5 at 9: 21 PM, 5 at 9:22 PM, 6 at 10:14 PM 06/21/24: LVN B documented a pain level of 3 at 8:43 PM, 6 at 10:44 PM and 2 at 1:03 AM. 06/23/24: LVN B documented a pain level of 2 at 9:33 PM 06/26/24: LVN B documented a pain level of 2 at 9:24 PM and 11:27 PM. 06/30/24: No documentation for this date. 07/07/24: LVN B documented a pain level 1 at 9:34 PM and 6 at 9:17 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/21/24: 0 all day 07/26/24: LVN B documented a pain level of 3 1:25 AM 10/09/24: 0 all day Record review of Resident #1's progress notes, dated 03/16/24-10/17/24, revealed the following: LVN B documented on 6/17/24 at 10:23 PM Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML Give 0.25 ml by mouth every 4 hours as needed for Pain or Air Hunger; PRN Administration was: Effective; Follow-up Pain Scale was: 0 Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML Give 0.25 ml by mouth every 4 hours as needed for Pain or Air Hunger very agitated. LVN B documented on 6/21/24 at 1:03 AM Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML Give 0.25 ml by mouth every 4 hours as needed for Pain or Air Hunger; PRN Administration was: Effective; Follow-up Pain Scale was: 2 Note Text : Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML Give 0.25 ml by mouth every 4 hours as needed for Pain or Air Hunger told son he was hurting and he requested pain meds LVN B documented on 7/08/24 at 2:35 AM Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML Give 0.25 ml by mouth every 4 hours as needed for Pain or Air Hunger; PRN Administration was: Effective; Follow-up Pain Scale was: 1 LVN B documented on 7/26/24 at 9:25 PM Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML Give 0.25 ml by mouth every 4 hours as needed for Pain or Air Hunger; PRN Administration was: Effective; Follow-up Pain Scale was: 0 LVN B documented on 7/26/24 at 4:26 AM Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML Give 0.25 ml by mouth every 4 hours as needed for Pain or Air Hunger; PRN Administration was: Effective; Follow-up Pain Scale was: 0 The DON documented on 10/10/24 at 6:11 PM Notified Family Member I of the discrepancy in his medication. Explained that we are actively looking into it. Also explained that it has not affected his care or well-being in any way (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 9:00 AM, the DON stated LVN D was a new nurse who had come to work the previous week and found a discrepancy in Resident #1's morphine count. She said LVN E was the nurse who was getting off, and LVN D was the oncoming nurse. She said LVN D reported to her that Resident #1's morphine was reported under the documented amount on the MAR. She said she and the ADON looked; about 8 MLs were missing. She stated she looked at the log and found discrepancies in the documentation, which did not coincide with what was in the bottle. She said she looked at the EMR, and the documentation there also did not coincide with what was in the bottle and what was on the paper MAR. During her investigation, she reviewed that LVN B had administered 7 of the 9 doses that Resident #1 received. She said that it was difficult to determine when the discrepancy happened other than the documentation. She said the discrepancy could have occurred between April 2024 and October 2024. She said that only nurses have access to the narcotics. She said that the last time the morphine was filled was in April 2024. She said she was responsible for ensuring that nurses followed the policy and counted the medications. She said she had not checked the carts before the discrepancy was identified. She said the ADON, and registered nurses were responsible for maintaining the carts and count sheets. She said this had not happened before. She said the potential negative outcome was that the resident's morphine could be missing and that residents could potentially miss doses of medication. She said Resident #1's morphine was PRN, and he did not miss any doses. She said she was unaware that the liquid morphine was not being counted. She said she never physically saw them count but could hear the nurses outside of her office counting. She said she was familiar with and trained on the medication administration policy. She said training over the medication process and shift change was taught upon hire and through in-services periodically. She said new nurses shadow a tenured staff for a couple of days before they work alone. She said medication training, including medication count, was standard nurse training, and none of her nurses are new nurses. She said she did not have any documentation to indicate that nurses had been trained specifically on the facility shift change medication count process. She said it was her expectation that the oncoming and off-going nurse count all medications to include liquid morphine. She said the nurses were responsible for accurate counts, and she believed the reason that no one was counting the liquid morphine was because it was not being administered frequently. She said all the nurses trusted each other's word that liquid morphine was accounted for. She said Resident #1's morphine was no longer in the facility as it was picked up the day before the interview. She said she had pictures and would provide them. She said that she indicated in writing where the morphine level was and where it should have been. During an interview on 10/17/24 at 9:05 AM, the ADM stated she was familiar with and had been trained on the medication administration policy. She stated that the potential negative outcome of not following the policy and not reconciling medications was that there could be oversight of medication administration and missing medications. She said this could place residents at risk for missing medications. She said staff could also be impaired if they took the medications and provided care for residents. She said she was unaware that Resident #1's liquid morphine was not being counted during shift change. She said it was her expectation that the facility process and policies were followed. She said that what should have been happening was that at shift change, medication counts should have occurred with the oncoming nurse and outgoing nurse. She said they both should confirm all medication inventory, including liquid medications. She said she was ultimately responsible for all the activities that were carried out in the facility. She said the reason she was given why the discrepancy was missed was the nurses were not counting the liquid morphine and had become relaxed in the process. She said the nurses were taking each other's word that the medication had not been given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 11:26 AM, the Pharmacy Operations Manager stated that they did chart reviews when the consultant was in the facility. He stated he was not sure if the counts were audited. He said a count sheet was sent with each medication and reconciled after each dispense. The said the facility filed the sheet when they were done with the medications. He said they sent a count sheet to reconcile the count, which was how they could track medications. If the resident was out of the medication earlier than usual, the facility has to start the request process over, order, and give a reason why the medication was out. It depends on the documentation as to how soon the medication could be refilled, and this could cause a delay in the resident receiving their medication. During an interview on 10/17/24 at 11:32 AM, Pharmacy Consultant F stated she has not been going to the facility since May 2024. She said Pharmacy Consultant G has been going in her place. She said when she was attending in person, she would talk to them about anything they needed to be aware of. She would complete a medication storage review. She checked the carts and did a control drug audit simultaneously. If it were drug destruction day, she would participate in the destruction. The controlled drug audit was random, where she would go through the cart and pick at least 5 drugs and made sure that everything they signed out was given was in PCC. She said she tried to check liquid morphine but did not always. She said liquid morphine was hard to measure and that it typically came with a little more than 30 ML. She said 1-2 MLs were hard to see, but 8 MLs were a significant amount missing, which was concerning. She said during her audits, she had never seen any issues outside of documentation. She said there were times when the medications were given but not documented, but they could be reconciled with PCC, paper MAR, and the medication. Attempted to contact Pharmacy Consultant G on 10/17/24 at 11:57 AM and she did not answer. A message was left, but no return call was received. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 12:04 PM, the ADON stated Resident #1 did not use the morphine often and that the morphine had been in the facility since April 2024. She said the discrepancy in the morphine should not have happened, and she and all of her staff should have been counting the liquid morphine every day. She said during shift change, they were not counting but were verbally stating whether or not they used the morphine that day. She said the staff were never physically laying eyes on the morphine bottle. She stated she had never been present at any time the morphine was used but was in the facility one time when LVN C had administered the medication. She said she was unsure of the date but that it was the day or so before the discrepancy was identified. The ADON stated she had never checked the MAR (paper or in the EMR). She said it was not one of her job duties before the discrepancy in the morphine was identified by LVN D. She said she did not know who was responsible for monitoring the count sheets before the discrepancy in the morphine was identified. She said every nurse employed at the facility was not counting the liquid morphine, and she knew this because she interviewed them all, and they admitted that they were not counting them. She said she was told by the nurses that they knew better, and they were not counting the liquids. She said that because of the discrepancy, all nurses were reprimanded. She said she had not cross-checked the resident's pain scale with the administration of the morphine for Resident #1. She said the potential negative outcome of not following the medication administration policy and counting all medications was there could be missing doses, especially if the staff did not know that the medication was gone. She said it could affect the resident because he may not have the needed medication. She said Resident #1 did not miss any doses as it was a PRN medication. She said a new bottle of morphine usually had a little over 30 MLs. She said she had been trained in medication administration and was familiar with the medication administration policy. Medication administration was a part of being a nurse. She said she expected that all medications, including liquid morphine, would be counted during each shift and that each person who took the medication cart would be responsible for completing the task of counting the medications. She said she did not have a reason why the liquid morphine was not counted but that she had been working all over the place due to staffing and did not have a reason to audit. She said she did not realize it was a problem until it was. During an interview on 10/17/24 at 12:35 PM, LVN H stated Resident #1 rarely ever needed pain medication outside his scheduled pain medication. She stated she did not notice the discrepancy in the morphine. She said that they would eyeball the morphine but that they all trusted each other, and that was why it was not being counted. She said she had been trained to count all medication. She said she was unaware that there was morphine missing. She said the potential negative outcome was that morphine could go missing. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 12:54 PM, LVN D stated she worked roughly at the facility for about a week. She was unsure of the date, but it was at least a week ago, and it had to be her 2nd day working at the facility. She said she believed it could have been Thursday, 10/10/24. She stated she came in and did the counts with LVN E. She said the medications were accurate, but the liquid morphine for Resident #1 was not. She said she immediately called and notified the ADON and DON. She said she observed the liquid morphine under 20 ML, but the sheet said 27.75 ML. She said morphine was always over, and that amount missing was alarming. She said the DON and ADON told her they would address it once they arrived at the facility. She said the count sheet looked like someone noticed it, and someone wrote over it on 07/26/24. She said it was her understanding that no one was counting the liquid morphine and that they had become relaxed about counting it. She said LVN C had said they were taking each other's word. She said that as a nurse, it was a part of their education to count all medications, but she had not specifically been trained at the facility. She said that on her first day, she worked the floor, and the day she identified the discrepancy was her second day. She said that she did not even know Resident #1 had liquid morphine. She said she did not count it on her first day. She said the sheet for it was hidden behind another sheet in the count book. She said she had to make a tab and label it liquids. Attempted an interview on 10/17/24 at 1:35 PM with LVN C and it was unsuccessful because the phone number was incorrect. During an interview on 10/17/24 at 1:41 PM, LVN A stated she no longer worked at the facility and had not worked there for about a month. She said she had never administered morphine to Resident #1. She said she could not verify that it was her signature on the MAR without seeing it. She said Resident #1 usually did not need morphine. She said they counted all medications at shift change and did not need to count the morphine because it was not given that she was aware of. During an interview on 10/17/24 at 1:46 PM, LVN E worked the night shift before the discrepancy in the morphine was identified. She stated she was unsure of the exact date. She said when she came on shift, she did not know that Resident #1 had any morphine but noticed it when she was getting off. She said the documentation said there should have been 27 ML, but there was 22 ML. She said she had never counted the liquid morphine and was unsure when the last time it was counted. She said the narcotic box was deep, and it was hard to see in the back. She said this was why she did not see it before. She said it was nursing 101 that you count all the medications when you come on shift and when you go off shift. She said she was an agency nurse and did not receive any specific training on medication administration when she came to the facility. During an interview on 10/17/24 at 1:52 PM, LVN B stated she no longer worked at the facility. She said she only administered liquid morphine to Resident #1 a few times. She said a few times was at least two times over a few months. She said she knew when he needed pain medication because of his behavior. She said usually, if an aide said he moaned while being changed, she would know he was in pain. She said she had been trained to count all medications, including liquids. She said when she worked at the facility, they counted all medications. She said one nurse would call out the number, and they would look at the medication together. During an interview on 10/17/24 at 2:49 PM, Resident #1 could not answer any questions about his medication administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 3:00 PM, the DON stated that there was no written policy that specified all medications should be counted. She stated that this was under the standard of practice. During an interview on 10/17/24 at 3:05 PM, the ADM stated that the medication administration policy was generalized and that they would intervene as appropriate if it was not followed. During an interview on 10/22/24 at 4:07 PM, LVN C stated that he was unaware that there was any morphine missing until the ADON told him. He stated that he was the last to administer medication to Resident #1. He said the amount he documented on the MAR sheet was the correct amount left after administering the medication. He said he was unaware if staff had become relaxed in counting but that he counted all medicines, including the liquid morphine. He stated he believed that the bottle was switched. He said he had been trained to count all medications and could not speak for other nurses as to whether they were counting all medications during shift change. He said each individual nurse was responsible. He said the potential negative outcome was staff could be taking the residents' morphine. He said only the nurses had access to the nurses' cart. Record review of the facility policy, Administering Oral Medications, revised October 2010 revealed: Purpose The purpose of this procedure is to provide guidelines for the safe administration of oral medications. Preparation Assemble the equipment and supplies needed. Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure. Medication Administration Record The policy did not reveal any further information regarding the documentation and reconciliation process, but did refer to the facility policy, Documentation of Medication Administration. Record review of the facility policy, Documentation of Medication Administration, revised April 2007 revealed: Policy Statement The facility shall maintain a medication administration record to document all medications administered. Policy Interpretation and Implementation (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse or certified medication aide (where applicable) shall document all medications administered to each resident on the residents' s medication record (MAR). Administration of medication must be documented immediately after (never before) it is given.