STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2023
NAME OF PROVIDER OR SUPPLIER: Lauderdale Christian Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 2019 County Road 394, Killen, AL 35645	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, the Alabama Department of Public Health Online Incident Reporting System, review of a facility investigative file, and review of a facility policy titled Medication Administration, the facility failed to ensure Employee Identifier (EI) #3 Licensed Practical Nurse (LPN), administered morphine pain medication to Resident Identifier (RI) #1 as ordered by physician. This was cited as a result of the investigation of complaint/report number AL00043318 and had the potential to affect RI #1, one of three sampled residents who received the pain medication, morphine at the facility. Findings include: On 2/8/2023 the State agency received a report from the facility on the Online Incident Reporting System. The report documented the incident type as Abuse-Neglect. The narrative summary of the incident documented: . (EI #3) LPN, is accused of not giving a resident . 12am (12:00 AM) morphine. The date and time of the occurrence was reported to be 2/2/2023 at 12:00 AM. A facility policy titled Medication Administration with a revised date of 1/10/2023 documented: Policy: Medications are administered by licensed nurses, . as ordered by the physician and in accordance with professional standards of practice, . Policy Explanation and Compliance Guidelines . 17. Sign MAR (Medication Administration Record) after administered. RI #1 was admitted to the facility on [DATE] and had diagnoses of Cerebral Palsy and Chronic Pain. RI #1's PHYSICIAN ORDERS documented an order dated 9/15/2021 for 2.5 milliliters (ml) per 5 milligrams (mg) of Morphine Sulfate to be given to RI #1 by mouth every six hours at 6:00 AM, 12:00 PM (noon), 6:00 PM, and 12:00 AM (midnight) for pain. Review of the facility investigative file for RI #1 revealed a typed document titled Accusation of Failure to Administer Resident Medications that was signed by EI #1 DON and dated 2/14/2023 and signed by EI #3 LPN. Review of this document revealed the following: (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/7/23 Social Services was interviewing residents and staff regarding alleged verbal abuse . A resident . stated she (EI #3) does not always bring . the midnight dose of . medications. A fellow charge nurse was able to substantiate the allegation. . (EI #3) was called in . and questioned about the medication violation. She agreed that she did not always give the midnight dose of morphine due to resident sleeping. I questioned her how often this happens and she said, a couple of nights a week. She has been documenting on the EMAR (Electronic Medication Administration Record) that she was administering said dose. 2/8/23 . I pulled the resident's . (RI #1) EMAR back to 12/16/22 along with the controlled substance inventory record. Nurse (EI #3) signed both documents indicating medication administration. I spoke with resident, and (he/she) stated (he/she) only got (his/her) midnight dose when the weekend nurse was working. (He/She) said, I don't see (EI #3) until 0545 (5:45 AM) in the morning. Administrator . DON (EI #1), were present with (EI #3) and Pharmacist (EI #5) was on conference call. Questions were asked related to the whereabouts of the medication that was documented but not dispensed. (EI #3) stated several times that she does not know. She admitted again to signing it out on the EMAR and the inventory record. I had printed proof and showed her each time that is was shown to be administered by her. She stated, a habit of clicking through the EMAR and logging on substance inventory record. She stated on rounds at approx. 1130pm (approximately 11:30 PM) resident would be asleep. She admitted she never went back at midnight to administer the morphine, which was scheduled for midnight. She would then document on said records but never drew up the medication. The count was always correct, and she could not explain how that was. Employee was brought back in . liabilities explained. She was informed that grounds for termination were based on . allegations made by a resident, falsifying documents on the EMAR . Narcotic Inventory Record, . not following MD (medical doctor) orders and no follow up as to why. On 9/18/2023 at 2:31 PM RI #1 was asked about receiving morphine. RI #1 said, it was every six hours. RI #1 said, sometimes he/she did not receive the midnight dose if EI #3 was working. The surveyor was unable to reach EI #3, Licensed Practical Nurse (LPN) for interview after multiple attempts. On 9/19/2023 at 5:30 AM, EI #4 LPN was interviewed. She said she worked with EI #3 a few nights a week. EI #4 said, when interviewed by the social worker, she had reported to her that when they worked together she did not see EI #3 open the medication cart or narcotic drawer to get the morphine for RI #1 at midnight. When asked how many residents received medication at midnight, EI #4 said, she was not sure, but RI #1 was to get morphine every six hours at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. EI #4 stated she never destroyed or counted narcotics with EI #3. On 9/19/2023 at 9:55 AM EI #2 Social Service and Abuse Coordinator, said she was told by EI #4 about EI #3 not giving medications at night. EI #2 said, when she interviewed RI #1, the resident said sometimes he/she got the medication at midnight and sometimes did not. EI #2 said, she looked in RI #1's medical record and realized morphine was a routine order. EI #2 said, RI #1 reported to her that (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EI #3 gave it at 5:30 AM or 6:00 AM. EI #2 said, EI #3 was signing it out as given at the 12:00 AM dose but was not giving it. On 9/19/2023 at 3:38 PM EI #5 Pharmacist, was interviewed. EI #5 said, she was on the phone call when EI #3 was asked about the morphine she did not give and several times EI #3 said, she did not know. EI #5 said, while on that call EI #3 said that on rounds about 11:30 PM, RI #1 would be asleep and she would document the morphine as given. On 9/19/2023 at 3:40 PM EI #1 Director of Nursing (DON) was asked about the investigation into RI #1's morphine. EI #1 said, the order was morphine 2.5 ml/5 mg, it was due routinely every six hours at 6:00 AM, 12 Noon, 6:00 PM, and 12:00 midnight. EI #1 said, EI #3 told them in an interview that she had not given the morphine a couple nights a week. EI #1 said, the medication was signed off on the MAR. EI #1 said, EI #3 was asked what she did with the morphine, and EI #3 repeatedly said she did not know but agreed she, EI #3, did not always give the morphine if RI #1 was sleeping. EI #1 said, they had EI #3 back at the facility on 2/14/2023 and she admitted she was signing it off on the Medication Administration Record and out in the narcotic record, but would not tell what she was doing with it. EI #1 said, they asked EI #3 if she was using it herself and she kept saying she did not know. EI #1 said, the facility discovered EI #3 was not giving RI #1 the morphine on 2/4/2023 during interviews. EI #1 said, the morphine was signed out as given every time. When EI #1 was asked about the policy for nurses giving medications, EI #1 said, they were to follow doctor orders, give to the resident, the right medication, route and time. EI #1 was asked how EI #3 followed the doctor's orders when the morphine midnight dose was not given. EI #1 said, she did not and also did not notify the Medical Doctor. EI #1 said, the concern for the resident if the nurse did not give scheduled medication ordered by the physician was the resident could have more pain. The facility took immediate actions to correct the non-compliance by: ____________________________________ Plan of correction * Terminated Employee EI #3, LPN on 2/8/23 * Interviewed residents with BIMS of 15 as to getting scheduled medications * Educated all nurses regarding medication administration policy, falsifying resident records and the medication hold process to be completed by 2/15/23. * Monitored nurses for medication administration competency, comparing the correct medication and dose with the MAR. * A narcotic count by the ADON or designee. Monitored all nurses for one week to be completed by 2/15/23. * Pharmacist will do audit of all narcotics to be completed by 2/15/23 * Results will be reviewed by DON and reported to QAPI on Emergency meeting 2/15/23 To be completed at the quarterly meeting 4/19/23.