STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265185	A. BUILDING _____ B. WING _____	C 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CAPE GIRARDEAU	365 SOUTH BROADVIEW STREET CAPE GIRARDEAU, MO 63703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language	F 573		

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

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.

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F 573	Continued From page 1	F 573		

that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure all residents or residents' authorized representatives were given access to view medical records in a timely manner when staff failed to give one resident (Resident #5) out of 6 sampled residents, access to view the resident's medical record within the required 24 hours after a request had been made. This had the potential to affect all the residents in the facility. The facility's census was 94.

The facility did not provide a policy regarding medical records requests.

Review of Resident #1's annual Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 01/17/25, showed:
- A Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment;
- Diagnoses of anemia (blood does not have enough red blood cells and hemoglobin, a protein found in the red blood cells, to carry oxygen all through the body), coronary artery disease (damage or disease in the heart's major blood vessels), hypertension (condition in which the force of the blood against the artery walls is too high), diabetes (a group of diseases that result in too much sugar in the blood), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), arthritis (swelling and tenderness in one or more joints causing joint

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F 573	Continued From page 2 pain or stiffness that often gets worse with age), anxiety (intense, excessive and persistent worry and fear about everyday situations), and depression (persistent feelings of sadness, hopelessness, and loss of interest in activities once enjoyed.) Review of the resident's demographics admission record showed the facility listed the resident as his/her own responsible party. During an interview on 02/26/25 at 10:00 A.M., Resident #5 said he/she requested a copy of all his/her medical records and a copy of an internal investigation regarding a complaint made against a staff member. Resident #5 said he/she wrote the request, so it would be in writing and gave it the Director of Nursing (DON) on 02/13/25. Resident #5 said the facility still has not given him/her any of the requested records. Review on 02/26/25 at 10:00 A.M. of a photocopied letter dated 02/13/25 provided by Resident #1 showed the resident requested all the medical records the facility had for him/her and a copy of an internal investigation involving a staff member from a prior complaint. During an interview on 02/26/25 at 3:45 P.M., the Administrator and Director of Nursing (DON) said Resident #5 gave the DON a handwritten request for records on 02/13/25, the same day they gave Resident #5 a letter regarding a room change. The DON said the resident's request was emailed to their legal department. The DON said he/she knows they must give residents their records within 24 hours of requesting them, but the facility process requires all medical records request be sent to their legal department first before they	F 573		

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F 573	Continued From page 3 release any records. The Administrator said he/she didn't think they sent the request to their legal department. The DON said yes, they emailed it to them. The DON said they were told they couldn't fulfill the request due to Resident #5 wanting copies of an internal investigation. When asked about the medical records request portion, the Administrator said sometime after the request was received, he/she went to speak with Resident #5 to clarify what specific medical records he/she wanted. The Administrator said Resident #5 kept talking about the internal investigation. The Administrator said he/she asked about the medical records request portion again and Resident #5 said he/she just wanted the internal investigation. The Administrator said there was no documentation regarding their conversation in Resident #5's progress notes. The Administrator said he/she has a word document on his/her computer he/she referred to as a "tic sheet" with information regarding Resident #5, including the conversation about the medical records request. When asked for clarification on what he/she meant by a "tic sheet", he/she said it was a running word document where he/she would make a "tic mark" and put a note regarding interactions with Resident #5. The Administrator said he/she had documented the discussion with Resident #1 regarding medical records and could provide a copy of the "tic sheet." During an interview on 02/26/25 at 4:45 P.M., Resident #5 said the Administrator has never come to him/her to ask about the records request. Resident #5 said he/she was very clear in his/her written request that he/she wanted all of his/her medical records. Resident #5 said the DON told him/her they sent the request to the	F 573		

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F 573	Continued From page 4 legal department later that same day on 02/13/25, but has not heard back regarding the request since then. During an interview on 02/26/25 at 5:45 P.M., the DON said he/she was mistaken, and the records request he/she was thinking of was for a different resident. The DON said there were no emails with the facility legal department regarding the records request made by Resident #5. The DON said she does not remember the request asking for medical records, only the internal investigation. Review of facility word documents regarding Resident #1 provided by the facility showed: - No documentation regarding the conversation the Administrator had with Resident #5 about medical records; - A document, dated 02/14/25, regarding the request for a copy of an internal investigation, with no mention of medical records, signed by the Administrator and the DON. Review of Resident #5's progress notes in the electronic medical record showed: - A nursing note, dated 02/13/25 at 3:57 P.M., "This resident left note on this DON desk requesting medical records and a copy of incident report dated 10/27/24. Resident informed that the note was received and forwarded to administration to be approved. Plan of care ongoing." During an interview on 02/27/25 at 2:11 P.M., the Administrator said, to his/her knowledge, Resident #5 never requested a copy of his/her medical records. The Administrator said if the resident requested a copy of medical records, they would have given them to him/her. The	F 573		

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F 573	Continued From page 5 Administrator said Resident #5 could have written the records request, had somebody copy it and claim he/she gave it to the DON when he/she did not. The Administrator said Resident #5 never gave them a request for medical records, only a request for an internal investigation. The DON reported to the Administrator that he/she remembered receiving a handwritten records request from Resident #5, but does not remember the request mentioning wanting medical records, only a copy of an internal investigation. The Administrator said he/she did not forward a medical records request for Resident #5 to the legal department of their corporation. During an interview on 02/27/25 at 2:30 P.M., the DON said there is a progress note dated 02/13/25 regarding the resident asking for medical records, but he/she does not recall that happening and offered no further explanation. The DON said he/she did not forward a medical records request for Resident #5 to their legal department. Complaint #MO00249530	F 573		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure an accurate and consistent	F 678	Past noncompliance: no plan of correction required.	

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F 678	Continued From page 6 system was in place to direct staff when to initiate basic life support for one resident (Resident #1) when on 11/12/24 the Phlebotomist came in around 5:00 A.M. and came to nurse's station and said the resident would not wake up. Licensed Practical Nurse (LPN) E went to the room and the resident did not have a pulse. LPN E and Certified Nurse Aid (CNA) C went to the nurse's station to check the report sheet for code status. The resident was a full code. LPN E returned to the room to begin Cardiopulmonary Resuscitation (CPR) while CNA C checked the electronic medical record for code status and called the code overhead. After a few compressions, CNA C returned to the room and stated the resident was a Do Not Resuscitate (DNR) according to the electronic records. LPN E stopped compressions and 911 was not called. Record review upon the resident's admission, 8/13/24, a DNR was signed. On a 9/10/24 re-admission a Full Code was signed. On 10/10/24 the status was changed to DNR with no order or signature. The resident's spouse said the resident should have been a full code. The facility census was 94. The Administrator was notified on 03/18/25, of the Immediate Jeopardy (IJ) past non-compliance, which occurred on 11/12/24. The facility provided training and in-servicing for all staff regarding the facility's CPR policy and using proper definitions/verbiage when writing and receiving orders for CPR/DNR. The IJ was corrected on 12/11/24. Review of the facility's policy titled, "Advance Directives and Advance Care Planning," dated 09/26/24, showed: - Residents have the right to self-determination	F 678		

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F 678	Continued From page 7 regarding their medical care. This includes the right of an individual to direct his or her own medical treatment, including the right to execute or refuse to execute an advance directive; - It is required that the patient is asked about advanced directives, and to document any wishes the patient might have with regard to the care they want or do not want; - If an adult individual is incapacitated at the time of admission and is unable to receive information to articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law; - The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time; - Do Not Resuscitate (DNR) order -A medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer cardiopulmonary resuscitation (CPR-life saving measures) in the event of cardiac or respiratory arrest. Existence of an advance directive does not imply that a resident has a DNR order. The medical record must show evidence of documented discussions leading to a DNR order; - Competent - Residents have the right to actively participate in their plan of care. The resident has the right to designate a representative, in accordance with State law, and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. A resident is competent to make a health care decision if he or she understands the nature	F 678		

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F 678	Continued From page 8 of his or her illness, understands the treatment options available to him or her, understands the consequences of refusing such treatments, and is able to make and communicate decisions about his/her medical treatment; - Incompetent - When a resident is "incompetent," he/she is unable to make his or her own decisions. A resident should not be presumed incompetent unless a physician renders an opinion of such, and even then, such presumption could be rebutted or challenged. A resident is in fact incompetent only when a court with jurisdiction over the resident declares such. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court. The resident's wishes and preferences must be considered in the exercise of the rights by the representative; - Residents or their responsible parties receive materials concerning their rights under applicable laws to make decisions regarding their medical care, including the right to accept or refuse medical care, the right to accept or refuse medical/surgical treatment, organ donation requests, and the formation of advance directives upon admission; - A written description of the facility's policies regarding advance directives and applicable State law is provided to the resident or resident representative. Information is provided in a manner easily understood by the resident or resident representative; - The resident and/or family, upon admission, to determine the need and knowledge relative to advance directives and advanced care planning; - Residents may revise an advance directive either orally or in writing. With an oral reversal, charting is due immediately, the physician is notified immediately, an immediate notation is	F 678		

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F 678	Continued From page 9 made on the care plan, and an immediate entry is made in the medical record. With written reversals, the physician is notified, and the plan is permanently adjusted. The physician must give an order for any changes in the advance directives; - If the resident leaves the facility temporarily (e.g., ER visit, hospital stay, or diagnostic procedure), a copy of the advance directive is sent with the resident. The facility should also ensure advance directive status (e.g., DNR, DNI) is communicated to the receiving provider and transporting provider; - Each time the resident is admitted to the facility, quarterly, and when a change in condition is noted in the resident condition, the facility should review the advance directive and advance care planning (ACP) information. This review should focus on if the existing advance directives and ACP match the current goals of care for the resident. The social services director or designee should document this conversion in the medical record and assist as needed with updating the documents that need revision in accordance with state and federal requirements; - Residents who are competent at the time of admission and who have not previously executed an advance directive are given the opportunity to do so with the assistance of an interdisciplinary team, consisting of, but not limited to: the Medical Director, Executive Director, Director of Nursing, Director of Social Services, chaplain, and others as appropriate. Social Services ensures that a copy of the advance directive is obtained for the resident's medical record and verifies that there is an appropriate physician's order in the resident's medical record as well; - In the absence of an advance directive, incompetent residents have treatment decisions	F 678		

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F 678	Continued From page 10 made by appropriate surrogate decision-makers. Such persons may include a court appointed guardian, the holder of a durable power of attorney, or a family member; - When the surrogate decision-maker is not the holder of a durable power of attorney (or a court appointed guardian) and where conflict arises as to the care provided or withheld, the facility provides all medical care until the conflict is resolved or otherwise ordered by a court of law; - Documentation in the Minimum Data Set (MDS) should reflect the appropriate advance directives. This information is reviewed or updated, as appropriate, at least quarterly or more frequently if there is a significant change in the resident's medical condition. Each quarter the care plan team reviews with the resident, his or her advance directives to ensure that they are still the wishes of the resident. Such reviews are made during the quarterly assessment process and recorded on the Resident's Assessment Instrument (RAI); - Do Not Resuscitate (DNR) - Regardless of whether the resident is in a persistent vegetative state or has a terminal condition, all Life Care Centers of America's residents receive full resuscitative measures unless a DNR is written in the resident's medical record and is identified in the resident's advance directive. While the physician's order is pending, the documented verbal wishes of the resident or resident's representative regarding DNR status will be honored, unless state specific guidelines differ; - Social Services or Nursing Administration's documentation of the DNR must be present in the medical record regarding the DNR status and discussion with the resident and/or resident's representative on the consequences and implications of this status. The physician is	F 678		

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F 678	Continued From page 11 notified regarding any questions concerning the appropriateness of the resident's code status; - A physician's order and written consent from the resident or resident's representative must be obtained. While the physician's order is pending, staff should honor the documented verbal wishes of the resident or the resident's representative regarding CPR unless state-specific regulations differ; - DNR order is flagged appropriately on the resident's chart to alert staff as to status; - Social Services and/or a member of Nursing Administration reviews the DNR status with the resident and/or family and the receiving physician within 72 hours of admission; - The resident or resident's representative must sign an informed consent as required by state specific requirement indicating that the resident consents to a "DNR" or "no CPR" or "no resuscitation" in the event of cardiac arrest or respiratory failure; - The DNR order is incorporated into the resident's care plan and is periodically reviewed, at least quarterly, including supportive care and comfort measures. These measures will not be withheld when a DNR order exists; - DNR orders may be revoked at any time but must be documented in the resident's chart as such with consent of the resident or the resident's representative; - The resident's physician is notified of any change in condition regardless of the DNR order; - The Director of Nursing or designee establishes a system to inform all direct care staff of the resident's DNR status. - If the resident is discharged from the facility and re-admitted, the DNR status must be reviewed to determine if it is still appropriate and desired by all parties involved. A new order for DNR is	F 678		

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F 678	Continued From page 12 obtained at that time. 1. Review of Resident #1's medical record showed: - An initial admission date of 08/13/24; - A code status form marked and signed DNR (Do Not Attempt Resuscitation) on 08/13/24 by the resident's spouse; - A readmission date of 09/10/24; - A code status form marked and signed full code on 09/10/24 by the resident; - A DNR order, dated 10/10/24, with no documentation as to why the order was changed from full code to DNR; - No documentation of any contact being made with the resident, the resident's family, or physician to obtain proper authorization for a code status change on 10/10/24. Review of the resident's care plan, last revised 10/16/24, showed: - Resident had an advance directive to be a DNR, date initiated 08/14/24; - Code status would be reviewed on a quarterly basis and as needed (prn), date initiated 08/14/24; - No mention of code status changing to full code, which was signed by the resident, on 09/10/24; - No mention of DNR change on 10/10/24. Review of the resident's BIMS (Brief Interview for Mental Status: score 0 to 7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 cognition intact) showed: - On 08/20/24, BIMS score was five out of 15; - On 09/27/24, BIMS score was 12 out of 15; - On 10/24/24, BIMS score was 15 out of 15; - On 11/02/24, BIMS score was 15 out of 15.	F 678		

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	265185	A. BUILDING _____ B. WING _____	C 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CAPE GIRARDEAU	365 SOUTH BROADVIEW STREET CAPE GIRARDEAU, MO 63703

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F 678	Continued From page 13 Review of the resident's BCAT (Brief Cognitive Assessment Tool to show cognition with scoring from 0 to 50 with 50 being cognitively intact) done from 09/11/24 through 10/08/24 showed a score of 33, stating cognitive impairment and/or mild stage dementia. Review of the resident's hospital record, dated 09/10/24, showed: - Upon discharge from the hospital on 09/10/24, the resident was at his/her baseline mental status per spouse alert and oriented to time, person, place, and situation; - Patient has continued to have waxing and waning (increases and decreases in consciousness) consciousness through the course of recent hospital admissions. The resident was placed on delirium precautions and received trazodone prn (as needed). The resident improved and was at baseline mental status at time of discharge on 09/10/24; - Code status at discharge: NO CPR. Review of witness statement from CNA C, dated 12/11/24 at 7:30 P.M., showed: -CNA took the resident to the bathroom at about 2:00 A.M. on 11/12/24 to use the toilet and had a bowel movement (as reported by the CNA). The CNA put the resident back to bed after using the bathroom. When the lab staff arrived, lab staff went into resident's room and came out to the nurse's station and told facility staff that the resident was not responding. CNA J went into the resident's room, came back out, and said "go get LPN E". LPN E, CNA J, CNA D, and CNA C went into Resident #1's room. LPN E checked the resident and said he/she had no pulse. CNA C went to the nurse's station and called the code blue overhead and checked the report sheet	F 678		

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F 678	Continued From page 14 which said full code. CNA C then turned on the computer and when the computer screen came up, CNA C checked the resident's name and the computer said he/she was DNR. CNA C then ran down to the room and told the nurse the resident was a DNR and to stop compressions. The nurse stopped compressions and CNA C left the room. Review of witness statement from CNA D, dated 12/11/24 at 8:30 P.M., showed: - CNA D was on his/her assigned hall on 11/12/24 around 5:30 A.M., he/she saw commotion and went to the other staff members who stated the resident was unresponsive. CNA D asked if the resident was a full code. LPN E said they looked and said the resident was a full code. CNA D grabbed the crash cart and took it into the room. LPN E and CNA D placed the backboard under the resident and LPN E started compressions. CNA D gave a breath or two via ambu bag (a device to deliver air to someone not breathing or with difficulty breathing). Someone came to the room and said the resident was a DNR. Compressions stopped. Review of witness statement from LPN E, dated 12/11/24 at 7:45 P.M., showed: - Phlebotomist came in around 5:00 A.M. and came to nurse's station and said the resident would not wake up. LPN E went to the room and the resident did not have a pulse. LPN E and CNA C went to the nurse's station to check the report sheet for code status. At this time the report sheet said full code. LPN E returned to the room to begin CPR while CNA C checked the electronic medical record for code status and called the code overhead. After a few compressions, CNA C returned to the room and stated the resident was a DNR. LPN E stopped	F 678		

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F 678	Continued From page 15 compressions and 911 was not called. LPN F came to assist with breaths via ambu bag. No breaths were given before stopping CPR. Review of an interview statement by phone interview between LPN E and the Administrator on 12/16/24 showed: - LPN E reports during the interview that when he/she entered the room of the resident, the resident's body was cool to touch. Review of the witness statement from LPN F, dated 12/11/24 at 8:05 P.M., showed: - LPN F saw commotion on unit 300 from unit 200 desk. LPN F went down the hall and followed the staff where the nurse had the crash cart. LPN F connected the ambu bag while the nurse started compressions. The nurse completed less than five compressions before CNA confirmed DNR status. LPN F did not give any breaths. After CPR was stopped, LPN F returned to unit 200. Review of an interview statement by phone interview between LPN F and the Administrator on 12/16/24 showed: - LPN F reported during the interview that when he/she entered the room of the resident, the resident's body was cold to touch and the resident's color was dusky blue. During an interview on 02/26/25 at 3:30 P.M., the Director of Nursing (DON) said code status used to be on the report sheet. The code status was removed from the report sheet and so the report sheet currently does not have code status on them. Staff should look in the electronic medical record for the code status. During an interview on 02/27/25 at 8:15 A.M.,	F 678		

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F 678	Continued From page 16 Registered Nurse (RN) G said he/she would look in the computer for code status and not anywhere else. He/she would not look at anything like a report sheet for code status as that could not be accurate and lead to mistakes. During an interview on 02/27/25 at 10:46 A.M., LPN A said the resident was alert and oriented as far as he/she could tell. He/She said the resident was not confused. During an interview on 02/27/25 at 10:55 A.M., Social Services Assistant (SSA) said the resident was alert and oriented. When the resident first got to the facility, he/she was confused, but the last couple BIMS he/she did, the resident was alert and able to make his/her own decisions. The only time the spouse got involved when making decisions was when the resident suggested the spouse be involved. During an interview on 02/27/25 at 12:16 P.M., the resident's spouse said the only reason the resident was in the facility was for rehab. The spouse said the resident had been alert and oriented throughout his/her stay at the facility. He/she said there wasn't anything wrong with the resident's mental status until the morning of the 11th, which was the day before he/she passed. The spouse said the resident fought hard to live and was ready to fight and come home. The spouse said the resident did not want a DNR after the first initial DNR signed. The spouse said he/she was present when the resident signed his/her admission documentation, which included the full code. The spouse said the resident was very much alert and oriented at the time. During an interview on 02/27/25 at 1:40 P.M.,	F 678		

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F 678	Continued From page 17 Occupational Therapist (OT) H said he/she worked with the resident doing therapy. He/She said the resident seemed alert and oriented and could carry on a conversation just fine. He/She said therapy success staff had planned the resident a success story since he/she was close to completing therapy and going home soon. During an interview on 02/27/25 at 1:42 P.M., the Director of Rehab said he/she did not remember the resident's cognitive status off hand, but the BCAT score of 33 out of 50 is consistent with the BIMS score of 12 showing some cognition issues. During an interview on 02/27/25 at 2:11 P.M., the Administrator and DON said code status should be assessed upon admission, readmission, change of condition, at least quarterly and as needed. They said a change of code status should be reflected in the care plan. They said the process to change code status is if a resident has a BIMS of 12 or greater, they will discuss what a DNR and full code is and what they would like and if they have a BIMS of less than 12, then the POA or next of kin will be contacted. Staff can check code status in the electronic records system and in the plan of care. They said when a resident is requesting a code status change, the IDT team should be notified. The IDT team includes the Administrator, DON, MDS, Dietary Manager, Social Services, Activities, Housekeeping, Director of Rehab and Infection Preventionist. During an interview on 03/18/25 at 2:30 P.M., LPN M said on 10/10/24 he/she received a phone call from another staff person to change Resident #1's status to a DNR. LPN M said he/she did not know who the staff person was	F 678		

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F 678	Continued From page 18 that called and directed the change. He/She thought it might have been a nurse or human resources. LPN M did not verify the order with a signed consent for change of code status or notify the physician, resident and or family any changes. Complaint #MO00249411	F 678		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow physician's orders by not administering medications as ordered for one resident (Resident #1) out of six sampled residents. The facility's census was 94. Review of the facility's policy titled, "Reordering, Changing, and Discontinuing Medication Orders," dated 07/01/24, showed: - Facilities are encouraged to reorder medications electronically or by fax whenever possible; - Facility is encouraged to follow verbal reorders with a faxed copy to the pharmacy; - Electronic Orders ("e-Refill"): Authorized facility staff may use Omniview (Trademark) to electronically reorder resident; - Facility staff should review the transmitted re-orders for status and potential issues and pharmacy response; - Facility may order refill medications using other electronic medication ordering systems by using the new request or reordering feature of the	F 760		

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F 760	Continued From page 19 software and transmitting to the pharmacy; - Facility should retain a copy of the refill/order form communicated to the pharmacy to reconcile the medications delivered by the pharmacy. Review of Resident #1's medical record showed: - Admission date of 08/13/24; - Diagnoses of kidney (renal) transplant, congenital cytomegalovirus infection (virus similar to common cold), chronic kidney disease (ckd-kidneys not filtering waste properly), heart failure (heart not pumping and functioning like it should), chronic obstructive pulmonary disease (COPD- disease of lungs making breathing more difficult), essential hypertension (high blood pressure), pulmonary hypertension (high pressure affecting heart and lungs), urinary tract infections (UTIs) , and urine retention; -An order for tacrolimus oral capsule one milligram (mg) twice a day (bid) by mouth for renal transplant. May use home medication until pharmacy delivers, order dated 09/10/24. Review of the pharmacy delivery sheets showed: - Tacrolimus one mg capsule immediate release (IR) quantity 30 pills shipped on 09/10/24 and delivered on 09/11/24 at 4:02 A.M.; - Tacrolimus one mg capsule immediate release (IR) quantity 30 pills shipped on 10/02/24 and delivered on 10/02/24 at 11:59 P.M.; - Tacrolimus one mg capsule immediate release (IR) quantity 30 pills shipped on 10/25/24 and delivered on 10/25/24 at 10:59 P.M. Review of the resident's medication administration record (MAR), dated October 2024, showed: - Tacrolimus one mg bid by mouth not administered on 10/19/24 x two doses, 10/20/24	F 760		

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F 760	Continued From page 20 morning dose, 10/21/24 x two doses, 10/22/24 x two doses, 10/23/24 morning dose, 10/24/24 morning dose, and 10/25/24 x two doses; - 11 out of 14 opportunities missed from 10/19/24 through 10/25/24. Review of the resident's progress notes showed: - On 10/21/24 at 12:27 P.M., nurse notified pharmacy; - On 10/21/24 at 8:55 P.M., medication unavailable; - On 10/22/24 at 8:02 P.M., awaiting medication; - On 10/25/24 at 12:23 P.M., on order; - On 10/25/24 at 7:35 P.M., unable to obtain. During an interview on 02/27/25 at 12:16 P.M., the resident's spouse said he/she brought the medication, tacrolimus, from home for the facility to use until a prescription could be obtained. The spouse said the bottle was returned to him/her the next day and he/she was informed the facility did not need it, because they had obtained their own medication. The spouse said the bottle appeared to have approximately the same number of pills in the bottle. During an interview on 02/27/25 at 9:29 A.M., Pharmacy General Manager said a refill request for tacrolimus was put in on 10/02/24, filled on 10/02/24, and received by facility on 10/02/24. Another refill was requested, filled, delivered, and received by facility all on 10/25/24. During an interview on 02/27/25 at 2:11 P.M., the DON said he/she would expect staff to notify the pharmacy when a refill for a medication is needed if it's a standard medication within seven days of the medication being out. The nurse passing the medications would be responsible for requesting	F 760		

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F 760	Continued From page 21 the refill. The med tech should tell the charge nurse when the medication is running low, so they know the refill is needed. He/she would expect staff to administer medications as ordered. He/she said if a home medication is brought into the facility for use, he/she would expect staff to make a progress note of how much of the medication is available and it would be stored in the medication cart unless it needs to be refrigerated. The DON said he/she would expect staff to inform the family if they are running low and need more. During a telephone interview on 03/14/25 at 12:43 P.M., the hospital Patient Safety and Quality Improvement Manager responded to questions regarding the transplant medication. The questions were answered by a transplant nephrologist medical doctor. The doctor said if a patient is on tacrolimus 1 mg twice a day for renal transplant and they missed seven days of the medication the main concern with skipping the medication for one week is it increases the risk for transplant rejection. The doctor said it is concerning to go that long without any doses because it increases the risk for transplant rejection and kidney dysfunction if the medication is not taken for a week. The doctor said the time frames vary from patient to patient on how soon rejection or kidney dysfunction will occur after missing medications. For some patients, symptoms can occur after a few days and other patients may take up to a month. The doctor said the CMV titer is very low, so the patient having CMV would not cause any additional concerns. The doctor said if the prescribed medication is not available, the facility would normally call the transplant office and they would provide recommendations for a different medication that	F 760		

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F 760	Continued From page 22 may be available at the facility. Complaint #MO00249411	F 760		

Missouri Department of Health and Senior Services

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A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II Refer to F760.	A4055		
A8011	19 CSR 30-88.010(11) Inform Medical Cond. - Access to Med Records A physician shall fully inform each resident of his or her health and medical condition unless medically contraindicated. If the physician determines the resident's medical condition contraindicates the resident being fully informed of his or her diagnosis, treatment or any known prognosis, the medical record shall contain documentation and justification of this signed by the physician. If there is a legally authorized representative to make health-care decisions, or the resident has designated any individual to have access, that person shall be fully informed of the resident's medical condition and shall have free access to the resident's medical records for that purpose, subject to the limitations provided by a power of attorney, duly-executed authorization or any federal law. I/II This regulation is not met as evidenced by: Class II Refer to F573.	A8011		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Cindy Zucker RN, BS TITLE 4/9/2025 (X6) DATE

PLAN OF CORRECTION

Provider/Supplier Name:	Life Care Center of Cape Girardeau
Street Address, City, Zip:	365 S Broadview St. Cape Girardeau, MO 63703
Date of Survey:	3/18/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265185

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under State and Federal law. The admission of the plan of correction does not constitute an admission on the part of Life Care Center of Cape Girardeau as to the accuracy of the surveyor's findings nor the conclusion drawn there from. The facility's submission of this plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. The plan of correction is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the plan of correction ___4/16/25_____. Compliance will be maintained as provided in the plan of correction. Please free to contact Life Care Center of Cape Girardeau at 573-335-2086. We respectfully request a desk review for compliance review.	

F 573	**What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice:** Resident #5 currently resides at the facility and received Medical Records on 3/5/25 **How will you identify other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the alleged deficient practice ED/Designee will perform an audit will be done to ensure Residents are notified of their right to access PHI in the "Notice of Privacy Practices" given upon admission.	
F 573	**What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** ED/Designee will educate HIMS Director or designees on the Policy and Procedure of Handling a Resident's Request to Access/View Medical Records. ED/Designee will monitor Medical Records requests by documenting and recording requests to ensure facility policy and procedures are followed so records can be viewed in a timely manner. **How the facility plans to monitor its performance to make sure that solutions are sustained:** ED/Designee will audit Medical Records request report with appropriate follow-up during morning clinical to ensure records requests are provided in a timely manner 5 days per week ongoing The results of the audits will be reviewed in the Quality Assurance Performance Improvement Committee (QAPI) monthly for three months or until substantial compliance is maintained. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached ED/Designee will perform an audit will be done to ensure Residents are notified of their right to access PHI in the "Notice of Privacy Practices" given upon admission.	

	The current resident will receive a copy of the notice of privacy practices-alert Copy will be sent to RP/POA's for those who are not alert	
F760	**What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice:** Resident #1 no longer resides in the facility **How will you identify other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the alleged deficient practice MAR/Cart audit to completed to ensure medications are available with follow-up as indicated	
F760	**What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** DON/Designee will educate Licensed Nurses/CMT's on the medication ordering process, including notifying MD/DON/Designee for direction when medications are not available, utilizing ekit/Omnicell and reordering medications when there is 7 days of dosage remaining **How the facility plans to monitor its performance to make sure that solutions are sustained:** DON/Designee will audit PCC MAR Omission report with appropriate follow-up if omissions are noted and/or med is documented as not available 5 days per week ongoing The results of the audits will be reviewed in the Quality Assurance Performance Improvement Committee (QAPI)	

	monthly for three months or until substantial compliance is maintained. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.