

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>03086N</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/29/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRAND ROYALE, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2900 NE KENDALLWOOD PKWY GLADSTONE, MO 64119</b>
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A4797	<p><b>19 CSR 30-86.047(46) Safe &amp; Effective Medication System</b></p> <p>The administrator shall develop and implement a safe and effective system of medication control and use, which assures that all residents' medications are administered by personnel at least eighteen (18) years of age, in accordance with physicians' instructions using acceptable nursing techniques. The facility shall employ a licensed nurse eight (8) hours per week for every thirty (30) residents to monitor each resident's condition and medication. Administration of medication shall mean delivering to a resident his or her prescription medication either in the original pharmacy container, or for internal medication, removing an individual dose from the pharmacy container and placing it in a small cup container or liquid medium for the resident to remove from the container and self-administer. External prescription medication may be applied by facility personnel if the resident is unable to do so and the resident's physician so authorizes. All individuals who administer medication shall be trained in medication administration and, if not a physician or a licensed nurse, shall be a certified medication technician or level I medication aide. I/II</p> <p>This regulation is not met as evidenced by: Class II</p> <p>Based on interview and record review, the facility staff failed to implement an effective system of medication administration when the staff administered Resident #1's Lorazepam Oral Concentrate 2MG/ML as needed (PRN) dose of Lorazepam Oral Concentrate one hour after administering the resident's scheduled dose of the medication. The facility census was 24.</p>	A4797		

Missouri Department of Health and Senior Services  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



*Shawna Green*

*LNHA*

*6/12/25*

STATE FORM

6899

LSZ711

If continuation sheet 1 of 8

Missouri Department of Health and Senior Services

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A4797	<p>Continued From page 1</p> <p>1. Review of Resident #1's medical chart showed: -Diagnoses included: Heart failure, type 2 diabetes, asthma, chronic obstructive pulmonary disease (COPD), and cerebral infarction.</p> <p>Review of Resident #1's physician order sheet (POS) dated 5/2/25 showed Resident #1 had orders for: -12/21/24 Lorazepam Oral Concentrate 2 milligram/milliliter (MG/ML), Give 0.5 ml by mouth two times a day for anxiety/shortness of air; -7/13/23 Lorazepam Solution 2 MG/ML, Give 0.25 ml by mouth every 4 hours as needed for anxiety/agitation.</p> <p>Review of a signed statement written by LIMA A showed: -He/She administered a scheduled dose of Lorazepam to Resident #1 on 5/21/25 at 8:00 P.M.; -He/She also administered a PRN dose of Lorazepam on 5/21/25 at 9:00 P.M.</p> <p>During an interview on 5/29/25 at 3:00 P.M. CMT A said: -He/She administered a scheduled dose of Lorazepam to Resident #1 on 5/21/25 at 8:00 P.M.; -The resident thought the syringe was empty and she did not get any of the medication for the scheduled dose; -He/She called the Administrator, and she instructed him/her to give the resident a PRN dose; -He/She administered a PRN dose of Lorazepam to the resident on 5/21/25 at 9:00 P.M.; -He/She believed the resident's PRN Lorazepam order was for 0.25 ml by mouth every hour as</p>	A4797		

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A4797	<p>Continued From page 2</p> <p>needed for anxiety/agitation.</p> <p>During an interview on 5/22/25 at 1:35 P.M. the Administrator said: -On the evening of 5/21/25, CMT A called her and said resident said he/she did not get any medication out of the syringe for his/her 8:00 P.M. dose and believed the syringe was empty; -She told CMT A that "if the resident said he/she didn't get it, give him/her another dose"; -She believed the resident's PRN order was to get Lorazepam every hour.</p> <p>During an interview on 6/12/25 at 8:35 A.M., Hospice Nurse A said: -He/She expected facility staff to wait four hours between doses or contact hospice for approval to give the PRN dose without waiting the four hours; -He/She would have called the hospice physician to get approval for the second dose.</p> <p>During an interview on 5/29/25, at 3:30 P.M., the Administrator said: -She expected all staff to verify physician orders prior to administering a medication; -She expected all medications to be accurately administered and recorded on the MAR.</p> <p>MO254623</p>	A4797		
A4809	<p>19 CSR 30-86.047(47)(G) Medication Administration, Documented</p> <p>Medication Orders. (G) The administration of medication shall be recorded on a medication sheet or directly in the resident ' s record and, if recorded on a medication sheet, shall be made part of the resident ' s record. The administration shall be</p>	A4809		

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A4809	<p>Continued From page 3</p> <p>recorded by the same individual who prepares the medication and administers it. II/III</p> <p>This regulation is not met as evidenced by: Class II*</p> <p>Based on interview and record review the facility failed to document administered medications on the medication administration record (MAR) for one resident (Resident #1) of three sampled residents. The census was 24.</p> <p>Review of the facility policy titled, "Narcotic Administration and Sign-Off Resident Rooms," last updated 5/2/25 showed:</p> <ul style="list-style-type: none"> <li>- The licensed staff member administering the narcotic must record the date, time, medication, and dose;</li> <li>-The staff member also must sign the Medication Administration Record (MAR) immediately after administration.</li> </ul> <p>1. Review of Resident #1's medical chart showed diagnoses included: Heart failure, Type 2 Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD), and Cerebral Infarction.</p> <p>Review of Resident #1's physician order sheet (POS) dated 5/2/25 showed orders for:</p> <ul style="list-style-type: none"> <li>-12/21/24 Lorazepam Oral Concentrate 2 MG/ML, Give 0.5 milliliters (ml) by mouth two times a day for anxiety/shortness of air;</li> <li>-7/13/23 Lorazepam Solution 2 MG/ML, Give 0.25 ml by mouth every 4 hours as needed for anxiety/agitation.</li> </ul> <p>Review of a signed statement written by LIMA A showed:</p> <ul style="list-style-type: none"> <li>-He/She administered a scheduled dose of</li> </ul>	A4809		

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A4809	<p>Continued From page 4</p> <p>Lorazepam to Resident #1 on 5/21/25 at 8:00 P.M.;</p> <p>-He/She administered an PRN (as needed) dose of Lorazepam on 5/21/25 at 9:00 P.M.</p> <p>Review of Resident #1's MAR did not indicate that any PRN doses of Lorazepam were administered on 5/21/25.</p> <p>Review of the resident's controlled substance record for Lorazepam Solution 2 MG/ML, Give 0.25 ml by mouth every 4 hours as needed for anxiety/agitation showed a dose was administered on:</p> <p>-5/8/25 at 6:00 A.M.;</p> <p>-and on 5/24/25 at 11:00 P.M.;</p> <p>-No other doses were recorded for the month of May 2025.</p> <p>During an interview on 5/29/25, Certified Medication Technician (CMT) A said:</p> <p>-He/She administered a PRN dose of Lorazepam to the resident on 5/21/25 at 9:00 P.M.;</p> <p>-He/She may have forgotten to record the dose on the MAR.</p> <p>During an interview on 5/29/25, at 3:30 P.M., the Administrator said she expected all medications administered to be accurately recorded on the MAR.</p> <p>*The higher classification merited due to the extent of the violation.</p> <p>MO254623</p>	A4809		
A4817	19 CSR 30-86.047(51)(A)(1) Schedule II Meds-Reconcile Each Shift, Record	A4817		

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A4817	<p>Continued From page 5</p> <p>Records shall be maintained upon receipt and disposition of all controlled substances and shall be maintained separately from other records, for two (2) years.</p> <p>(A) Inventories of controlled substances shall be reconciled as follows:</p> <ol style="list-style-type: none"> <li>Controlled Substance Schedule II medications shall be reconciled each shift; II</li> </ol> <p>This regulation is not met as evidenced by: Class II</p> <p>Based on observation, interview and record review showed the facility failed to reconcile inventory of controlled substance schedule II medications by two personnel at every shift change for one of three (Resident #1) sampled residents. The facility census was 24.</p> <p>Review of the facility's undated policy titled, "Two-Person Narcotic Count Policy" showed:</p> <ul style="list-style-type: none"> <li>-Narcotic counts must be performed at every shift change and when transferring responsibility of controlled substances;</li> <li>-The count would be done by two licensed personnel;</li> <li>-All narcotics both oral and injectable were to be counted;</li> <li>-The count must be completed, witnessed, and signed off by both individuals;</li> <li>-Discrepancies should be immediately reported to the charge nurse or supervisor</li> </ul> <p>1. Review of Resident #1's medical chart showed:</p> <ul style="list-style-type: none"> <li>-He/she resided on the 700 hall;</li> <li>-Diagnoses included: Heart failure, type 2 diabetes, asthma, chronic obstructive pulmonary</li> </ul>	A4817		

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A4817	<p>Continued From page 6</p> <p>disease (COPD), and cerebral infarction.</p> <p>Review of Resident #1's physician order sheet (POS) dated 5/2/25 showed Resident #1 had a orders for:</p> <ul style="list-style-type: none"> <li>-12/21/24, Lorazepam Oral Concentrate 2 milligram/milliliter (MG/ML), Give 0.5 ml by mouth two times a day for anxiety and shortness of air;</li> <li>-7/13/23, Lorazepam Solution 2 MG/ML, Give 0.25 ml by mouth every 4 hours as needed for anxiety/agitation;</li> <li>-6/5/24, Morphine Sulfate ER Oral Tablet Extended Release 15 MG, Give 1 tablet by mouth two times a day for pain.</li> </ul> <p>Review on 5/29/25 of Resident #1's controlled substance record for the scheduled Lorazepam Oral Concentrate 2 MG/ML showed:</p> <ul style="list-style-type: none"> <li>-Level One Medication Aide (LIMA) B administered 0.5 ml on 5/29/25 at 8:00 A.M.;</li> <li>-The starting quantity was 3.75 ml, and after the 0.5 ml dose the ending quantity was 3.25 ml.</li> <li>-Observation on 5/29/25 at 1:50 P.M. showed there was only 0.25 ml in the bottle, indicating there was 3 ML deficit of the medication in the bottle compared to the amount documented on the narcotic sign out sheet.</li> </ul> <p>During an interview on 5/29/25 at 1:30 P.M., Certified Medication Technician (CMT) B said:</p> <ul style="list-style-type: none"> <li>-He/She administered 0.50 ml of Lorazepam to Resident #1 on 5/2/25 at 8:00 A.M.;</li> <li>-He/She did not verify how much medication was left in the bottle after drawing the 8:00 A.M. dose because it was too hard to tell how much was left in the bottle;</li> <li>-He/She recorded that there was 3.25 ml left in the bottle because the previous staff that administered the medication recorded that there was 3.75 ml left in the bottle after administering</li> </ul>	A4817		

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A4817	<p>Continued From page 7</p> <p>0.50 ml. -He/She did not know how much medication was left in the bottle after he/she administered it at 8:00 A.M. -He/She confirmed there was 0.25 ml left in the bottle at 1:30 P.M. on 5/29/25.</p> <p>Review of the Narcotic Count Sheet for the 700 Hall, Medication Cart #3 showed a two-person count was not completed for the following shifts from 5/17/25 - 5/29/25: -5/17/25, 10:00 P.M. and; -5/27/25, 2:00 P.M.</p> <p>During an interview on 5/29/25, at 3:30 P.M., the Executive Director said: - She expected staff to reconcile the inventory of controlled substances by two personnel at the beginning and end of each shift.</p> <p>MO254623</p>	A4817		

## PLAN OF CORRECTION

<b>Provider/Supplier Name:</b>	The Grand Royale	
<b>Street Address, City, Zip:</b>	2900 NE Kendallwood Parkway, Gladstone Mo 64119	
<b>Date of Survey:</b>	Complaint Investigation completed May 29 <sup>th</sup> 2025	
<b>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</b>		
<b>ID PREFIX TAG</b>	<b>PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</b>	<b>COMPLETION DATE</b>
A4797	<p>The administrator has updated policy and procedure for administering psychotropic and narcotic medications</p> <p>The facility will identify other residents having the potential to be affected by the current practice.</p> <p>All current residents have the potential to be affected by the current practice.</p> <p>The facility administrator, DON and/or designee have provided educational training to CMT on the policy of Narcotic Administration and Sign off.</p> <p>The facility administrator, DON and/or designee will monitor this corrective process during each med cart narc and psychotropic audit.</p> <p>For all med cart Audits administrator, DON or designee will audit all psychotropics and Narcotics in pill and liquid form. Audits will be performed randomly 3 times a week for 4 weeks, 2 times a week for 4 weeks, weekly for 4 weeks, audits will continue until compliance is achieved.</p> <p>Corrective action will be completed by 6/20/2025</p>	
A4809	<p>The administrator has updated policy and procedure for Administering Medications</p> <p>The facility will identify other residents having the potential to be affected by the current practice.</p> <p>All current residents have the potential to be affected by the current practice.</p> <p>The facility administrator, DON and/or designee have provided educational training to CMT's on the policy of Administering Medication.</p>	

	<p>The facility administrator DON, and/or designee will monitor this corrective process during each med cart audit.</p> <p>For all med cart Audits administrator, DON or designee will audit all psychotropics and Narcotics in pill and liquid form. Audits will be performed randomly 3 times a week for 4 weeks, 2 times a week for 4 weeks, weekly for 4 weeks audits will continue until compliance is achieved.</p> <p>Corrective action will be completed by 6-20-2025</p>	
A4817	<p>The administrator has updated policy and procedure for Two person Narc count Policy and Adverse Consequences and Medication Errors.</p> <p>The facility will identify other residents having the potential to be affected by the current practice.</p> <p>All current residents have the potential to be affected by the current practice.</p> <p>The facility administrator, DON and/or designee have provided educational training to CMT's on the policies of: Two person Narcotic count Policy and Adverse Consequences and Medication Errors.</p> <p>The facility administrator, DON, and/or designee will monitor this corrective process during each med cart audit.</p> <p>For all med cart Audits administrator, DON or designee will audit all psychotropics and Narcotics in pill and liquid form. Audits will be performed randomly 3 times a week for 4 weeks, 2 times a week for 4 weeks, weekly for 4 weeks audits will continue until compliance is achieved.</p> <p>Corrective action will be completed by 6-20-2025</p>	
	<p>For all med cart Audits administrator, DON or designee will audit all psychotropics and Narcotics in pill and liquid form. Audits will be performed randomly 3 times a week for 4 weeks, 2 times a week for 4 weeks, weekly for 4 weeks, audits will continue until compliance is achieved.</p>	

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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.