

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20288C	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/01/2025
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NAME OF PROVIDER OR SUPPLIER GARDENS, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 WEST SUNSET SPRINGFIELD, MO 65807
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(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) COMPLETE DATE
A4797	<p>19 CSR 30-86.047(46) Safe & Effective Medication System</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: Clas II</p> <p>Based on record review and interview, the facility failed to maintain a safe and effective medication system when staff failed to ensure ordered medications were available for staff to administer and failed to administer medication as ordered based on blood pressure checks for one resident (Resident #1). The facility census was 99.</p>	A4797		

Missouri Department of Health and Senior Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

A. Brown

TITLE

Executive Director

(X6) DATE

5/29/25

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A4797	<p>Continued From page 1</p> <p>Review of the facility's policy titled "Medication System," dated 11/01/06, showed the following:</p> <ul style="list-style-type: none"> -It is the policy of the facility to administer medication upon the order of the physician in a safe, efficient, and systemic manner; -Medications ordered by the physician must be ordered from the pharmacy; -All medications shall be reviewed monthly and as needed; -Admission medications orders, new, or changed medication orders, or discontinued medication orders are received and/or transcribed by legally authorized staff members; -The community's licensed nurse or pharmacy consultant does a medication review on each resident as required by state regulatory agency. <p>1. Review of Resident #1's face sheet showed the following:</p> <ul style="list-style-type: none"> -Diagnoses included cognitive impairment with memory loss (memory thinking problems), lung nodule (spot on the lung), pleural effusion (condition where excess fluid accumulates in the cavity between the lungs and chest wall), atrial fibrillation (heart beats irregularly), type II diabetes (affects how the body uses glucose for energy) and hypertension (high blood pressure). <p>Review of the resident's December 2024 Physicians Order Sheet (POS) showed an order, dated 12/06/24, for allopurinol (used to prevent or lower high uric acid levels in the blood) 100 milligram (mg), give one tablet two times per day at 8:00 A.M. and 8:00 P.M.</p> <p>Review of the resident's December 2024 Medication Administration Record (MAR) showed the following:</p> <ul style="list-style-type: none"> -On 12/21/24, staff documented the allopurinol was not administered at 8:00 A.M. or 8:00 P.M., 	A4797		

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A4797	<p>Continued From page 2</p> <p>due to medication not available; -On 12/22/24, staff documented the allopurinol was not administered at 8:00 A.M., due to medication not available.</p> <p>Review of the resident's December 2024 POS showed an order, dated 12/06/24, for aspirin (used to treat aches and pains) 81 mg, give one tablet per day at 8:00 A.M.</p> <p>Review of the resident's December 2024 MAR showed on 12/21/24 and 12/22/24, staff documented aspirin not administered at 8:00 A.M. due to the medication not available.</p> <p>Review of the resident's December 2024 POS showed an order, dated 12/06/24, for atorvastatin (lower cholesterol) 20 mg, give one table per day at 8:00 P.M.</p> <p>Review of the resident's December 2024 MAR showed on 12/08/24, 12/21/24 through 12/23/24, and 12/27/24, staff documented atorvastatin not administered at 8:00 A.M. due to medication not available.</p> <p>Review of the resident's December 2024 POS showed an order, dated 12/06/24, for diltiazem (treats high blood pressure) 240 mg, give one capsule per day at 8:00 A.M.</p> <p>Review of the resident's December 2024 Medication Administration Record (MAR) showed on 12/21/24 and 12/22/24, staff documented diltiazem not administered at 8:00 A.M., due to medication not available.</p> <p>Review of the resident's December 2024 POS showed an order, dated 12/06/24, for hydralazine (used to treat high blood pressure) 10 mg, give</p>	A4797		

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A4797	<p>Continued From page 3</p> <p>one tablet by mouth, two times per day.</p> <p>Review of the resident's December 2024 MAR showed the following: -On 12/21/24, staff documented hydralazine not administered at 8:00 A.M., or 8:00 P.M., due to medication not available; -On 12/22/24, staff documented hydralazine not administered at 8:00 A.M. due to medication not available.</p> <p>Review of the resident's December 2024 POS showed an order, dated 12/06/24, for hydrochlorot (used to treat high blood pressure) 12.5 mg, give one tablet per day at 8:00 A.M.</p> <p>Review of the resident's December 2024 MAR showed on 12/21/24 and 12/22/24, staff documented hydrochlorot not administered at 8:00 A.M. due to medication not available.</p> <p>Review of the resident's December 2024 POS showed an order, dated 12/06/24, for levothyroxine (treats thyroid) 25 micrograms (mcg), give one tablet per day at 6:00 A.M.</p> <p>Review of the resident's December 2024 MAR showed on 12/22/24, staff documented levothyroxine not administered at 6:00 A.M. due to medication not available.</p> <p>Review of the resident's December 2024 POS showed an order, dated 12/06/24, for losartan (treats high blood pressure) 100 mg, give one tablet one time per day at 8:00 P.M.</p> <p>Review of the resident's December 2024 MAR showed on 12/21/24, staff documented losartan not administered at 8:00 P.M. due to medication not available.</p>	A4797		

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A4797	<p>Continued From page 4</p> <p>Review of the resident's December 2024 POS showed an order, dated 12/06/24, for metformin (treats high blood sugar) 500 mg, give one table by mouth at 8:00 A.M.</p> <p>Review of the resident's December 2024 MAR showed on 12/21/24, staff documented metformin not administered at 8:00 P.M. due to medication not available.</p> <p>Review of the resident's December 2024 POS showed an order, dated 12/06/24, for metoprolol (treats high blood pressure) 100 mg, give one tablet by mouth two times per day at 8:00 A.M. and 8:00 P.M.</p> <p>Review of the resident's December 2024 MAR showed the following: -On 12/21/24, staff documented metoprolol not administered at 8:00 A.M. or 8:00 P.M. due to medication not available; -On 12/22/24, staff documented metoprolol not administered at 8:00 A.M. due to medication not available.</p> <p>Review of the resident's December 2024 nurses' notes showed the following: -On 12/22/24, at 2:22 A.M., staff noted it looked like medications never got reordered when the medications brought in to the facility were finished. Staff e-faxed the resident's order, called the pharmacy, and left a message stating they need the medications as soon as possible. The resident did not get any of his/her meds on 12/21/24; -On 12/22/24, at 12:17 P.M., resident came to the nursing office and said he/she had not had his/her blood pressure taken or his/her medications in two days. Staff took the resident's</p>	A4797		

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A4797	<p>Continued From page 5</p> <p>blood pressure that measured 202 millimeters of Mercury (mmHg)/120 (mmHg). (Normal blood pressure is generally considered to be less than 120/80 mmHg.) Staff called pharmacy at 12:00 P.M. and they said the medications were on their way. Staff will give medications when they arrive. P.M. and bedtime medications needed to be held until later in the evening/night;</p> <p>-On 12/22/24, at 2:44 P.M., the resident's blood pressure measured 179/107 mmHg with pulse of 99 beats per minute (bpm). (Normal bpm between 60 and 100 bpm.);</p> <p>-On 12/22/24, at 2:52 P.M., resident received his/her medications at 1:40 P.M. Family came to office and spoke with certified medication technician (CMT). Explained to family he/she didn't know what happened. The resident was better now and blood pressure was better;</p> <p>-On 12/23/24, at 6:42 P.M., Health Services Director was notified that family would like to speak with him/her regarding some concerns brought to the attention of Executive Director. Family wanted to verify that the resident was to have a primary pharmacy. When resident admitted, resident brought his/her own medications and staff did not order a new supply in adequate timing due to admit nurse was told resident self administered. He/she explained that all new admits medications should be ordered from the pharmacy immediately to ensure this does not happen again.</p> <p>Review of the resident's medical record, dated December 2024, showed staff did not document notification of the resident's physician regarding the medications not being administered.</p> <p>Review of the resident's January 2025 nurse's notes dated 01/28/25, at 12/59 P.M., showed the resident's family told facility staff the resident's</p>	A4797		

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A4797	<p>Continued From page 6</p> <p>blood pressure had been high since staff got off on the the resident's scheduling of his/her blood pressure medications. Staff explained it might take time to get back to a therapeutic dose.</p> <p>Review of the resident's February 2025 POS showed the following: -An order, dated 02/03/25 through 2/17/25, to give one tablet of hydralazine 25 mg two times per day by mouth. Give one tablet of hydralazine 25 mg, by mouth one time daily as needed for systolic blood pressure greater than 140 mmHg in addition to routine. -An order dated 04/24/23 through 02/15/25, for staff to complete manual check of blood pressure and record two times daily at 8:00 A.M. and 8:00 P.M. Staff to fax readings and call physician if the blood pressure was above 140 mmHg.</p> <p>Review of the resident's February 2025 MAR showed the following: -On 02/04/25, at 8:42 P.M., staff recorded the resident's blood pressure was 141/97 mmHg. Staff did not document administration of the as needed hydralazine; -On 02/05/25, at 10:13 A.M., staff recorded the resident's blood pressure was 141/83 mmHg. Staff did not document administration of the as needed hydralazine; -On 02/05/25, at 9:54 P.M., staff recorded the resident's blood pressure was 199/101 mmHg. Staff did not document administration of the as needed hydralazine; -On 02/06/25, at 9:56 A.M., staff recorded the resident's blood pressure was 180/97 mmHg. Staff did not document administration of the as needed hydralazine; -On 02/07/25, at 9:25 P.M., staff recorded the resident's blood pressure was 152/91 mmHg. Staff did not document administration of the as</p>	A4797		

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A4797	<p>Continued From page 7</p> <p>needed hydralazine; -On 02/08/25, at 8:30 A.M., staff recorded the resident's blood pressure was 146/94 mmHg. Staff did not document administration of the as needed hydralazine; -On 02/08/25, at 11:03 P.M., staff recorded the resident's blood pressure was 148/89 mmHg. Staff did not document administration of the as needed hydralazine; -On 02/10/25, at 10:17 A.M., staff recorded the resident's blood pressure was 141/92 mmHg. Staff did not document administration of the as needed hydralazine; -On 02/11/25, at 8:40 P.M., staff recorded the resident's blood pressure was 166/99 mmHg. Staff did not document administration of the as needed hydralazine; -On 02/13/25, at 8:56 A.M., staff recorded the resident's blood pressure was 166/88 mmHg. Staff did not document administration of the as needed hydralazine; -On 02/14/25, at 8:17 A.M., staff recorded the resident's blood pressure was 152/90 mmHg. Staff did not document administration of the as needed hydralazine; -On 02/16/25, staff did not document blood pressure checks.</p> <p>Review of the resident's nurse's, dated 02/17/25, at 11:50 A.M., showed resident to have vital signs taken three times per day. He/she was to have blood pressure taken two hours after hydralazine given, if systolic is greater than 140 mmHG, then additional hydralazine should be given. Vital sign have to be faxed week to physician.</p> <p>Review of the resident's February 2025 POS showed the following:</p>	A4797		

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A4797	<p>Continued From page 8</p> <ul style="list-style-type: none"> -An order dated 02/17/25, for staff to check vitals three times per day, at 8:00 A.M., 2:00 P.M., and 8:00 P.M.; -An order, dated 02/18/25, if systolic blood pressure via manual cuff at 10:00 A.M., or 10:00 P.M., was still greater than 140 mmHg, give additional dose of hydralazine 25 mg by mouth up to twice daily; -An order dated 02/18/25 through 02/25/25, for 8:00 A.M. and 8:00 P.M., two tablets of hydralazine 25 mg by mouth twice daily and to check blood pressure two hours after administering hydralazine. -An order, dated 02/18/25, to fax blood pressure to doctor weekly on Tuesdays; -An order, dated 02/24/25, to fax vitals to doctor weekly. <p>Review of the resident's February 2025 MAR showed the following:</p> <ul style="list-style-type: none"> -On 02/18/25, staff administered the hydralazine at 8:00 P.M. Staff did not document a blood pressure reading two hours later; -On 02/19/25, at 12:15 A.M., the resident's blood pressure was 169/99 mmHg. Staff did not document physician notification of the reading over 140 mmHg; -On 02/20/25, at 12:09 P.M., the resident's blood pressure reading was 145/90 mmHg. Staff did not document physician notification; -On 02/21/25, at 12:50 A.M., the resident's blood pressure reading was 157/68 mmHg. Staff did not document physician notification; -On 02/25/25, at 11:35 P.M., the resident's blood pressure was 157/94 mmHg. Staff did not document physician notification; -On 02/27/25, at 1:42 P.M., the resident's blood pressure was 150/87 mmHg. Staff did not document physician notification; 	A4797		

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A4797	<p>Continued From page 9</p> <p>-On 02/28/25, at 12/27 P.M., the resident's blood pressure was 159/96 mmHg. Staff did not document physician notification;</p> <p>During an interview on 03/28/25, at 10:41 A.M., the resident said the following: -He/she brought medications to the facility from his/her prior assisted living; -He/she did not self-administer his/her medications; -He/she ran out of medications shortly after being admitted in December. He/she went without medications a couple of days; -His/her blood pressure was high during that time and has been high off and on since; -If his/her blood pressure was high, he/she took a PRN blood pressure medication.</p> <p>During an interview on 03/28/25, at 1:22 P.M., Level One Medication Aide (LIMA) A said the following: -He/she ordered medications by e-faxing through the computer when they're about seven days from running out; -Nurses are responsible for ordering new admission's medications from the pharmacy; -The medications are delivered every night; -He/she knew a resident's orders by looking at the MAR. It lists the dose, if they need vitals or blood pressure taken; -He/she followed the orders from the physician that show up on the computer; -He/she believed only certified staff can take a resident's blood pressures; -Staff administer the resident's medications; -The resident was supposed to have his/her blood pressure taken by an arm cuff, and he/she tried to do this; -He/she knew when the resident first came, he/she did run out of medications.</p>	A4797		

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A4797	<p>Continued From page 10</p> <p>During an interview on 03/28/25, at 1:55 P.M., CMT B said the following:</p> <ul style="list-style-type: none"> -He/she knew which medications to pass by looking at the MAR. It pops up the medications and any other orders at the time they need to be done; -He/she ordered medications by e-fax through the computer when they get low; -He/she didn't do anything with admissions, they're done by nursing; -He/she knew that some residents required blood pressures to be done when certain medications are taken; -If the blood pressure wasn't within certain parameters, there were usually orders to administer something else or contact the doctor; -He/she followed orders from the computer on what's needed, whether that be medications, or vitals. <p>During an interview on 03/28/25, at 2:40 P.M., the Health Services Director said the following:</p> <ul style="list-style-type: none"> -When a resident was admitted by nursing, they sent a medication list to the primary care provider and to the pharmacy to order the resident's medications; -The facility attempted to order the medications prior to the resident's arrival so the medications would be at the facility upon admission; -The pharmacy delivered twice per week; -Staff knew what medications and tasks that need to be completed by the MAR: -The primary care physician signs off on all medications and they're put into the electronic MAR; -The resident had an order to recheck his/her blood pressure after administering the two doses of hydralazine; -The resident did check his/her own blood 	A4797		

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A4797	<p>Continued From page 11</p> <p>pressure, however, he/she would expect staff to be checking the blood pressure as ordered: -He/she looked at the resident's December 2024 MAR saw the resident did go without medications for a day and half; -The nurse doing the admit was under the impression the resident was going to be self administering his/her own medications; -The admitting nurse did not send the orders to the pharmacy as the staff would normally do when admitting; -He/she did notify the doctor the resident was out of medications; -They do not have most medications in stock, just an overflow cart; -The resident did not self-administer his/her own medications.</p> <p>During an interview on 03/28/25, at 3:18 P.M., the Executive Director said the following: -LIMAs and higher pass medications and take vitals; -The nurse admits residents and the facility gets the medication list prior to the resident being admitted, so it can be sent to the pharmacy; -The pharmacy delivered daily and they try to have the resident's medications the day prior to admission; -He/she expected the licensed staff to order medications before a resident runs out; -If the a resident does run out, he/she would get the medications as quickly as possible even if it meant getting from a local pharmacy; -If a resident's medications did not come in, staff should be following up to see where they're at; -The facility does have some medications on hand; -Staff know what medications and tasks to complete by the physician's orders and the MAR; -He/she would expect staff to pass medications</p>	A4797		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20288C	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/01/2025
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NAME OF PROVIDER OR SUPPLIER GARDENS, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 WEST SUNSET SPRINGFIELD, MO 65807
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(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) COMPLETE DATE
A4797	Continued From page 12 as ordered; -He/she would expect staff to follow doctor's orders and take the blood pressure as ordered and do the vitals as ordered. If the doctor is to be notified, that should be done as well. MO00249625	A4797		
A4798	19 CSR 30-86.047(47)(A) Physicians Orders Followed Medication Orders. (A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. II/III This regulation is not met as evidenced by: Class II* Based on record review and interview, the facility failed to ensure all physician orders were followed when staff failed to document completion of vitals as ordered for one resident (Resident #1) with a history of high blood pressure. . The facility census was 99. 1. Review of Resident #1's face sheet showed the following: -Diagnoses included cognitive impairment with memory loss (memory thinking problems), lung nodule (spot on the lung), pleural effusion (condition where excess fluid accumulates in the cavity between the lungs and chest wall), atrial fibrillation (heart beats irregularly), type II diabetes (affects how the body uses glucose for energy) and hypertension (high blood pressure). Review of the resident's February 2025 Physician	A4798		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20288C	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/01/2025
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A4798	<p>Continued From page 13</p> <p>Orders Sheet (POS showed the following: -An order, dated 02/17/25, for staff to check vitals three times per day, at 8:00 A.M., 2:00 P.M., and 8:00 P.M.; -An order, dated 02/18/25, to fax blood pressure to doctor weekly on Tuesdays; -An order, dated 02/24/25, to fax vitals to doctor weekly.</p> <p>Review of the resident's vitals, for February 2025, showed from 02/17/25 through 02/28/25, staff completed all vitals signs one time per day, instead of the three times per day ordered.</p> <p>Review of the resident's March 2025 POS showed the following: -An order, dated 02/17/25, for staff to check vitals three times per day, at 8:00 A.M., 2:00 P.M., and 8:00 P.M.; -An order, dated 02/18/25, to fax blood pressure to doctor weekly on Tuesdays; -An order, dated 02/24/25, to fax vitals to doctor weekly.</p> <p>Review of the resident's vitals, dated March 2025, showed the following: -On 03/01/25 through 03/12/25, staff checked vitals two times per day; -On 0315/25 through 03/18/25, vitals were checked two times per day; -On the 03/20/25 through 03/24/25, vitals were check two times per day; -On 03/27/28, the vitals were checked two times.</p> <p>During an interview on 03/28/25, at 10:41 A.M., the resident said the following: -The staff take his/her blood pressure mostly on his/her wrist and it's supposed to be taken on the arm; -He/she does have an arm cuff and he/she does</p>	A4798		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20288C	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/01/2025
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A4798	<p>Continued From page 14</p> <p>use it to take his/her own blood pressure too; -The staff take his/her blood pressure daily.</p> <p>During an interview on 03/28/25, at 1:22 P.M., Level One Medication Aide (LIMA) A said the following: -He/she followed the orders from the physician that show up on the computer; -He/she believed only certified staff can take a resident's blood pressures; -The resident was supposed to have his/her blood pressure taken by an arm cuff, and he/she tried to do this; -He/she did not know how often the resident was supposed to have blood pressure or vitals taken.</p> <p>During an interview on 03/28/25, at 1:55 P.M., Certified Medication Tech (CMT) B said he/she followed orders from the computer on what's needed, whether that be medications, or vitals.</p> <p>During an interview on 03/28/25, at 2:40 P.M., the Health Services Director said the following: -The resident did check his/her own blood pressure, however, he/she would expect staff to be checking the blood pressure as ordered: -He/she saw on the MAR that the resident had an order for vitals three times per day and he/she was not aware the vitals were not being done; -Only LIMAs or higher can take vitals; -He/she would expect staff to do vitals as ordered; -The doctor did want the resident's blood pressure taken by manual cuff, and his/her staff are being trained to do this, but they're only LIMA and he/she notified the doctor the staff aren't trained to do this.</p> <p>During an interview on 03/28/25, at 3:18 P.M., the Executive Director, said the following:</p>	A4798		

Missouri Department of Health and Senior Services

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A4798	<p>Continued From page 15</p> <ul style="list-style-type: none"> -LIMAs and higher pass medications and take vitals; -Only LIMA's of higher levels, such as CMTs or nurses are able to take vitals; -He/she would expect staff to follow doctor's orders and take the blood pressure as ordered and do the vitals as ordered. If the doctor is to be notified, that should be done as well. <p>*The higher classification merited due to the extent of the violation and impact when combined with other deficiencies.</p> <p>MO00249625</p>	A4798		

PLAN OF CORRECTION		
Provider/Supplier Name:	The Gardens Assisted Living Community	
Street Address, City, Zip:	1302 W. Sunset, Springfield, MO 65807	
Date of Survey:	April 1, 2025	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	<p>This Plan of Correction ("POC") is submitted as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of The Gardens (the "Community") as to the accuracy of the surveyors' findings, nor the conclusions drawn therefrom. This POC is intended to constitute the Community's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Corrections on May 15, 2025</p>	
A4797	<p>19 CSR 30-86.47(46) Safe & Effective Medication System 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 physician/provider/providers' instructions using acceptable nursing techniques. The community shall employ a licensed nurse eight (8) hours per week for every thirty (30) residents to monitor each resident's condition 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 in 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 community personnel if the resident is unable to do so and the resident's physician/provider/provider so authorizes. All individuals who administer medication shall be trained in medication administration and, if not a physician/provider/provider or a licensed nurse, shall be a certified medication technician or level 1 medication aide.</p>	On or before May 15, 2025

Sharon, ED 4/25/25

A4797	<p>Corrective action will be/has been accomplished for the residents identified to be affected by the deficient practice by:</p> <ol style="list-style-type: none"> 1. In February 2025, a problem was identified regarding Resident #1 order and corresponding administration. 2. During an internal audit to include physician/provider medication validation, pharmacy audit and communication with Guardian pharmacy, the physician/provider's orders were clarified and entered appropriately into the resident MAR. 3. Following the implementation of the corrective action, there were documented instances where the residents' medications were not available for administration. 4. The community identifies all residents as potentially affected by this deficient practice. 5. Corrective action has begun and will be accomplished by: <ol style="list-style-type: none"> a. The community in-serviced staff on March 25 and 28, and again during the April 25, 2025 nursing meeting on the importance of safe and effective medication handling to include when to ordering/reorder medications, proper documentation of administration and follow-up of medication monitoring. All staff are and will be trained in safe and effective medication handling upon hire. b. Medications are to be ordered when supply reaches a count of no fewer than 7 doses remaining. c. HSD/Designee will monitor the Medication Exception Report a minimum of 3x per week for 4 weeks with documented findings. HSD/Designee will provide appropriate corrective action as indicated to include contacting pharmacy, educating staff and ensuring Physician/provider was notified of any discrepancies in medication administration from the physician order. d. All findings of the audits will be documented and submitted/reported to the ED for additional review during the monthly QA process to ensure that solutions are achieved and sustained. Additional interventions will be made as needed for the next 90 days or until substantial compliance is achieved. 	On or before May 15, 2025
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A4797		On or before May 15, 2025
A4798	<p>19 CSR 30-86.047(47)(A) Physician Orders Followed</p> <p>Medication Orders. (A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. II/III Corrective action will be/has been accomplished for the residents identified to be affected by the deficient practice by:</p> <ol style="list-style-type: none"> 1. In February 2025, a problem was identified regarding Resident #1 physician/provider order regarding completion of vitals as ordered. 2. Clarification of the physician/provider orders for frequency of checks, appropriate prn administration and reporting parameters were received and entered in the resident MAR. 3. Following the implementation of the corrective actions, there were noted instances where resident's vital sign checks and corresponding notification of vital sign checks to physician/provider were not documented as being completed per the physician/provider request. There were noted instances with lacking documentation of physician/provider notification, if the vitals were outside the parameters given in the physician/provider orders. 4. The community identifies all residents as potentially affected by this deficient practice. 5. The community in-serviced staff on March 25 and 28 and again during the April 25, 2025 nursing meeting on the importance of following physician/provider orders as written to include capturing/reporting vital signs per the parameters established. 6. HSD/Designee will audit all residents with vital sign orders outside the standard community policies. 7. HSD/Designee will monitor, a minimum of 3x per week for 4 weeks, the residents from the audit, and any residents with new vital sign monitoring orders. The findings will be recorded to ensure documentation and physician/provider notification is completed per the physician/provider order. Corrective action will be implemented as needed. 	On or before May 15, 2025

A4798	8. All findings of the audits will be documented and submitted/reported to the ED for additional review during the monthly QA process to ensure that solutions are achieved and sustained. Additional interventions will be made as needed for the next 90 days or until substantial compliance is achieved.	On or before May 15, 2025

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.