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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide care that met professional standards quality for one resident (Resident #2) from a sample of 13 residents. Facility staff failed to accurately transcribe the resident's physician orders on admission. The facility census was 74. Review of the facility policy titled "Administering Medications," dated April 2019, showed the following: -The Director of Nursing (DON) services supervises and directs all personnel who administer medications and/or have related functions; -If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician, or the facility's medical director to discuss the concerns; -Each nurses' station has a current Physician's Desk Reference (PDR - comprehensive reference book that compiles information about prescription drugs available, including details like dosage, side effects, and indications) and/or other medication reference; -Manufacturer's instructions or user's manuals	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Clara Merrill | TITLE: Adm | (X6) DATE: 3/10/25

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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related to any medication administration devices are kept with the devices or at the nurses' station.

Review of the facility's checklist titled "Admission Checklist," undated, showed the following:
-Admission medications verified by physician and pharmacy notified;
-Orders entered correctly;
-Admitting nurse and date;
-Items requiring follow-up;
-Nurse completing form and date.

Review of Resident #2's face sheet (a brief information sheet about the resident), showed the following:
-Admission date of 01/24/25;
-Diagnoses included aftercare following joint replacement surgery (post-operative care and monitoring that a patient receives after undergoing a joint replacement procedure), osteoarthritis (type of arthritis (painful inflammation and stiffness of the joints that occurs when flexible tissue at the ends of bones wears down) of left knee, and osteoporosis (condition in which bones have lost minerals-especially calcium-making them weaker, more brittle, and susceptible to fractures (broken bones)).

Review of the resident's baseline care plan, dated 01/24/25, showed staff noted see physician orders for medications.

Review of the resident's hospital discharge summary, dated 01/24/25, showed an order for alendronate (used to prevent and treat osteoporosis), 70 milligrams (mg) by mouth, one tablet every seven days.

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Review of the resident's Physician Order Sheet (POS), dated 01/31/25, showed an order, dated 01/24/25, for alendronate sodium oral tablet 70 mg, give one tablet by mouth in the morning for osteoporosis related to unilateral primary osteoarthritis, left knee.

Review of the resident's medical record showed the following:
-On 01/24/25, at 2:26 P.M., a system note showed alendronate sodium oral tablet 70 mg, give one tablet by mouth in the morning for osteoporosis related to primary osteoarthritis of left knee was outside of the recommended dose or frequency. The dosing regimen of 1 tablet daily exceeded the usual dosing regimen of 0.5 tablet every 7 days to 0.67 tablet daily.

Review of the resident's medical record showed staff did not document addressing the system notice related to the medication dosage.

Review of the resident's medical record showed an administration note date 01/25/25, at 9:45 A.M., showed alendronate 70 mg, give one tablet in the morning for osteoporosis related to primary osteoarthritis of left knee was not available and nurse notified.

Review of the resident's January 2025 Medication Administration Record (MAR) showed the following:
-On 01/25/25, staff documented alendronate was not administered due to medication not available;
-On 01/26/25, staff documented alendronate was not administered due medication not available;

Review of the resident's Physician Order Sheet (POS), dated 01/31/25, showed the prior order for

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alendronate was discontinued. A new order, dated 01/27/25, with start date of 02/02/25, for alendronate sodium oral tablet 70 mg, give one tablet in the morning every one week on Sunday.

Review of the resident's January 2025 Medication Administration Record (MAR) showed the following:
-On 01/27/25, staff documented the alendronate was administered.

During an interview on 02/06/25, at 11:00 A.M., Certified Medication Tech (CMT) A said if he/she had any concerns related to a medication order, he/she would talk to the charge nurse and the DON. If there was a medication error, it was to be reported to the charge nurse and DON. The nurse would contact the physician and the family. When preparing and administering medications for residents he/she followed the orders in the MAR for medication administration.

During an interview on 02/06/25, at 11:40 A.M., Licensed Practical Nurse (LPN) C said the charge nurse entered physician orders from the hospital discharge summary and notified the physician for approval before residents received medications. Chart audits were done by management, but he/she did not know when that was completed. The pharmacy completed a medication review at least once per month. The pharmacy would send recommendations by fax and the nursing staff notified the physician to review the recommendations and make changes according to the physician's order. If there was a medication error, staff was to complete the medication error sheet, notify the DON and the physician, and follow any physician orders.

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During an interview on 02/10/25, at 2:50 P.M., LPN E said that he/she usually was on the medication cart and the charge nurse was the one to enter orders for new admissions. There was a new admission checklist. Once the hospital sent the discharge summary, the charge nurse would send it to the physician to review and approve orders. The nurse would enter and he/she would help review the orders entered when available. He/she said when entering orders a screen will pop up if there was a drug to drug interaction alert or other warning about the drug. The nurse had to sign off on that page when it popped up.

During an interview on 02/06/25, at 11:25 A.M., Registered Nurse (RN) B said when a new resident was admitted, the charge nurse on shift should enter the hospital discharge medication orders in the computer system and notify the physician for review. He/she would send the list to the pharmacy to fill the medications. Once the admission was completed the DON or Assistant Director of Nursing completed chart audits. If notified of a medication error, he/she would notify the physician for orders, and notify the DON and Administrator.

During an interview on 02/11/25, at 3:35 P.M., LPN H said when he/she received a new admission, he/she would look for the hospital discharge final orders and go through the orders with the resident being admitted if the resident was alert, and verify that they seemed familiar to the resident. He/she would then verify the orders with the physician. Once the orders were entered into the computer, he/she would put the admission packet in the medical records box and was told that a copy was given to the

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administration staff to verify. If he/she was aware of a medication error, he/she would notify the physician and the family. He/she would monitor the resident for 72 hours and notify the physician of any issues. He/she would complete a risk management form, like an incident report. When he/she worked, if a CMT told him/her that something looked inaccurate on the MAR, he/she would thoroughly check into and investigate. He/she said it was not uncommon for him/her to find and fix errors.

During an interview on 02/10/25, at 4:30 P.M., LPN C and RN B both said the nurse getting the order from the physician would enter it into the electronic system onto the POS. If the system detected a problem with the dosing amount/time, an allergy, or a conflict with another current medication, a warning message will pop up on the screen stating the information. The nurse should see the message before continuing. A warning symbol would then appear next to the medication on the POS. When administering medications, the warning does not pop up on the MAR, but the nurse or medication technician could check the warning box for the medication on the POS.

During an interview on 02/06/25, at 11:50 A.M., the Interim DON said typically the charge nurse would put new physician orders into the computer and there would be a chart audit. The facility had gotten behind on chart audits. The nurse will now have the next shift nurse review the order entries because there had been some orders entered wrong. She was not aware of any outcome or medication errors due to the incorrect order entry.

During an interview on 02/06/25, at 2:15 P.M., the

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F 658	Continued From page 6 Corporate Nurse said the best practice for new resident admissions would be for the charge nurse to enter the orders from the hospital discharge summary and then to reconcile once entered into the computer. Staff should ask someone else to check their data entry of the orders. The interim DON should be doing chart audits. During an interview on 02/06/25, at 1:55 P.M., the Administrator said when a charge nurse received a new resident admission he/she should review and enter the orders from hospital discharge summary. The physician visited with the new resident as soon as possible. She was not aware if staff were completing chart audits after new admission. There had been three DONs in the past four months.	F 658		
	MO00249050			
F 760 SS=J	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 ensure residents were free of significant medication errors when staff failed to transcribe new admission orders correctly for one resident (Resident #1) resulting in staff administering two medications in excess of the ordered dosage amounts for five days. Once notified of the error, the staff did not document notification of the physician of the medication error to obtain further direction. The resident passed away on the day	F 760		

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the medication error was discovered. The facility census was 74.

The Administrator and the Corporate Nurse were notified on 02/06/25, at 4:10 P.M. of an Immediate Jeopardy (IJ) which began on 01/24/25. The IJ was removed on 02/06/25 as confirmed by surveyor onsite verification.

Review of the facility policy titled "Administering Medications," dated April 2019, showed the following:
-Medications are administered in a safe and timely manner, and as prescribed;
-The Director of Nursing (DON) services supervises and directs all personnel who administer medications and/or have related functions;
- Medications are administered in accordance with prescriber orders, including any required time frame;
-Medication errors are documented, reported, and reviewed by the Quality Assurance and Performance Improvement (QAPI -a data-driven approach to improving the quality of care and life for nursing home residents) committee to inform process changes and or the need for additional staff training;
-If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician, or the facility's medical director to discuss the concerns;
-Each nurses' station has a current Physician's Desk Reference (PDR - comprehensive

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reference book that compiles information about prescription drugs available, including details like dosage, side effects, and indications) and/or other medication reference;
-Manufacturer's instructions or user's manuals related to any medication administration devices are kept with the devices or at the nurses' station.

Review of the facility policy titled "Adverse Consequences and Medication Errors," dated February 2023, showed the following:
- The interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects;
- An adverse consequence refers to an unwanted, uncomfortable or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include:
-The staff and practitioner strive to minimize adverse consequences by following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication;
-Residents receiving medication are monitored for adverse consequences;
-Adverse consequences are promptly identified and reported;
-An adverse drug reaction (ADR) is a form of adverse consequences. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic and helpful effects of the drug; or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis or therapy.;
-Adverse drug reactions are reported to the

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F 760	Continued From page 9 attending physician and pharmacist, and to federal agencies as appropriate; -A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professionals providing services; -A significant medication-related error is defined as requiring medication discontinuation or dose modification; requiring hospitalization, or extending a hospitalization; resulting in disability; requiring treatment with a prescription medication; resulting in cognitive deterioration or impairment; life threatening; or resulting in death; -Review the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis; -When a resident receives a new medication order, review to ensure the dose, route of administration, duration, and monitoring are in agreement with current clinical practice, clinical guidelines, and/or manufacturer's specifications for use. Document the clinical rationale for using the medication if prescribed outside the accepted standard of practice; -Monitor the resident for medication-related adverse consequences when there is an addition of a new medication; discontinuation of an existing medication; an increase or decrease in dose or frequency; -Addition or discontinuation of enteral feedings; significant changes in diet that may affect medication absorption; or an medication error; -In the event of a significant medication-related error or adverse consequence, take action, as necessary, to protect the resident's safety and welfare; -Promptly notify the provider of any significant	F 760		

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error or adverse consequence;
-Implement the provider orders and monitor the resident for 24 to 72 hours, or as directed;
-Communicate the event to the oncoming shift as needed to alert staff of the need for continued monitoring;
-The QAPI committee is responsible for conducting a root cause analysis of medication administration errors to determine the source of errors; creating and implementing process improvement steps; and comparing results over time to determine that system improvements are effective in reducing errors.

Review of the facility's checklist titled "Admission Checklist," undated, showed the following:
-Admission medications verified by physician and pharmacy notified;
-Orders entered correctly;
-Admitting nurse and date;
-Items requiring follow-up;
-Nurse completing form and date.

Review of the "Diltiazem Prescribing Information," dated August 2023, showed the following:
-Diltiazem belongs to a class of medications called calcium-channel blockers;
-It works by relaxing the blood vessels, so the heart does not have to pump so hard;
-Diltiazem also increases the supply of blood and oxygen to the heart;
-Usual adult dose for hypertension (high blood pressure) initial dose of 120 milligrams (mg) to 240 mg orally once a day and increasing the dose as needed. Maintenance dose of 120 mg to 540 mg orally once a day;
-Maximum dose per day of 540 mg;
-Diltiazem may cause serious side effects including chest pain; fast, slow, or uneven heart

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rate; light-headed feeling; heart problems; swelling, rapid weight gain; feeling short of breath; liver problems; loss of appetite; upper right side stomach pain; tiredness; itching; dark urine; clay-colored stools; and jaundice (yellowing of the skin or eyes).
-Overdose symptoms may include low blood pressure, slow heart rate, severe dizziness, or fainting.

Review of the "Eliquis Medication Guide," dated September 2021, showed the following:
-Eliquis is a blood thinner medicine that reduces blood clotting;
-Eliquis lowers the chance of having a stroke by helping to prevent blood clots from forming;
-Most common side effects are bruising and may cause bleeding which can be serious and rarely may lead to death;
-Take Eliquis exactly as prescribed by the doctor;
-Take Eliquis twice every day with or without food;
-The recommended dose for most patients is 5 mg taken orally twice daily;
-The recommended dose of Eliquis is 2.5 mg taken orally twice daily for age greater than or equal to 80 years, body weight less than or equal to 132 pounds, or serum creatinine greater than or equal to 1.5 mg/deciliter (dL).

Review of Resident #1's face sheet showed the following:
-Admission date of 01/24/25;
-Diagnoses included acute respiratory failure with hypoxia (not enough oxygen in the blood or body's tissues), influenza due to influenza A (contagious respiratory illness) with other respiratory manifestations (symptoms that affect the lungs and airways, such as coughing, shortness of breath, and chest pain), congestive

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heart failure (CHF - a condition in which the heart can't pump enough blood to the body's other organs), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)), and chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe).

Review of the resident's baseline care plan, dated 01/24/25, showed the following:
-Full code (resident wanted to receive cardiopulmonary resuscitation (CPR - an emergency lifesaving procedure performed when the heart stops beating) and other life-saving treatments if their heart or breathing stops);
-Initial discharge goal to return to the community;
-Alert and cognitively intact;
-See physician orders for medications;
-Functional goal to improve functional status with physical therapy.

Review of the resident's hospital discharge summary, dated 01/24/25, showed the following medications to be continued on discharge:
-Apixaban (generic for Eliquis) 5 mg orally, take one-half tablet two times per day to thin blood and stroke prevention;
-Diltiazem (used to treat high blood pressure) 120 mg 24-hour capsule, take one capsule by mouth every morning to prevent arrhythmia (irregular heart beat).

Review of the resident's facility Physician Order Sheet (POS), dated 01/29/25, showed the following:
-An order, dated 01/24/25, for apixaban 5 mg, give one tablet by mouth two times a day for stroke prevention (twice the ordered amount on

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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) COMPLETION DATE
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the resident's hospital discharge orders);
-An order, dated 01/24/25, for diltiazem HCL (hydrochloride) ER (extended-release) beads capsule extended release 24-hour 360 mg, give one capsule two times a day for blood pressure (six times the ordered amount on the resident's hospital discharge orders).

Review of the resident's January 2025 Medication Administration Record (MAR) showed the following:
-On 01/24/25, staff did not administer the resident's apixaban 5 mg evening dose due to medication on order;
-On 01/24/25, staff did not administer the resident's diltiazem ER 360 mg evening dose due to medication on order.

Review of the resident's medical record showed the following:
-On 01/24/25, at 1:59 P.M., a system order note showed "the order you have entered is outside of the recommended dose or frequency. Diltiazem HCl ER Beads Capsule Extended Release 24 Hour 360 mg give 1 capsule by mouth two times a day for blood pressure. The dosing regimen of 1 capsule 2 times per day exceeds the usual dosing regimen of 0.33 to 1 capsule daily. The frequency of 2 times per day exceeds the usual frequency of daily

Review of the resident's medical record showed staff did not document regarding the system generated warning on 01/24/25.

Review of the resident's admission summary dated 01/24/25, at 2:57 P.M., showed resident arrived via medical transport accompanied by driver. Resident required stand by assist. Lungs

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clear to auscultation (listening to the sounds of lungs using a stethoscope) and respirations even and unlabored. Abdomen soft and bowel sounds active times 4. Continent of bowel and bladder. Alert and oriented times 4 and able to make wants and needs known. Denied pain at this time.

Review of the resident's Nursing Home Initial Physician Assessment, dated 01/25/25, showed the following:
-Blood pressure 110/70 millimeters of Mercury (mm/Hg - normal is less than 120/80 mm/Hg) and pulse 70 beats per minute (bpm) (normal is 60 to 100 bpm);
-Diagnoses included acute respiratory failure with hypoxia, influenza, and atrial fibrillation (irregular and rapid heart beat);
-Physician review of systems showed no edema (fluid trapped in body's tissues);
-Physician's plan showed to continue apixaban 5 mg twice per day and continue diltiazem 120 mg ER once per day.

Review of the resident's medical record showed staff did not follow-up to address the discrepancy between the discharge orders, orders entered, and the physician note on 01/25/25.

Review of the resident's January 2025 MAR showed the following:
-On 01/25/25, staff administered apixaban 5 mg morning and evening doses;
-On 01/25/25, staff administered diltiazem ER 360 mg morning and evening doses;
-On 01/26/25, staff administered apixaban 5 mg morning and evening doses;
-On 01/26/25, staff administered diltiazem ER 360 mg morning and evening doses.

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Review of the resident's facility POS, dated 01/29/25, showed the following:
-The prior order for diltiazem HC was discontinued on 01/27/25.
-An order, dated 01/27/25, for diltiazem HCL ER Beads Capsule Extended Release 24-hour 360 mg, give one capsule two times a day for hypotension (low blood pressure) (six times the ordered amount on the resident's hospital discharge orders).

Review of the resident's January 2025 MAR showed the staff documented the following:
-On 01/27/25, staff administered apixaban 5 mg morning and evening doses;
-On 01/27/25, staff administered diltiazem ER 360 mg morning dose;
-On 01/27/25, staff administered diltiazem ER 360 mg evening dose and noted the resident's blood pressure was 103/54 mm/Hg with a pulse of 65 bpm;
-On 01/28/25, staff administered apixaban 5 mg morning and evening doses;
-On 01/28/25, staff administered diltiazem ER 360 mg morning dose and noted the resident's blood pressure was 122/76 mm/Hg with a pulse of 64 bpm;
-On 01/28/25, staff administered diltiazem ER 360 mg evening dose and noted the resident's blood pressure was 115/79 mm/Hg with a pulse of 71 bpm.

Review of the resident's medical record dated 01/29/25, at 12:31 P.M., showed a pharmacy consultant note documenting he/she completed the monthly drug regimen review and noted medication errors. The consultant called and spoke with Licensed Practical Nurse (LPN) D. The order for diltiazem should be ER 120 mg

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every day and Eliquis should be 2.5 mg twice per day. Consultant also emailed DON, Administrator, Assistant Director of Nursing (ADON), and MDS Coordinator to ensure error corrected and let them know they need to notify provider of medication errors.

Review of the resident's facility POS, dated 01/29/25, showed the following:
-The prior order for apixaban and diltiazem were discontinued;
-An order, dated 01/29/25, for apixaban 2.5 mg, give 1 tablet by mouth two times a day for blood thinner;
-An order dated 01/29/25, for diltiazem HCL ER oral tablet extended release 24-hour 120 mg, give 120 mg by mouth in the morning for blood pressure, with a start date of 01/30/25.

Review of the resident's January 2025 MAR showed the staff documented the following:
-On 01/29/25, staff administered apixaban 5 mg morning dose;
-On 01/29/25, staff did not administer the diltiazem ER 360 mg morning and noted the resident's blood pressure was 87/57 mm/Hg with a pulse of 69 bpm.

Review of the resident's medical record showed staff did not document notification of the family or the physician of the medication errors.

Review of the resident's medical record showed staff documented the following:
-On 01/30/25, at 1:27 A.M., at approximately 9:50 P.M., the nurse went into the resident's room to administer medication. The nurse observed the resident lying in bed and was unable to arouse resident. The nurse checked the pulse apically

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(with a stethoscope at the bottom tip of the heart) for 1 minute with no pulse present. The certified nurse aide (CNA) on duty had seen the resident at approximately 7:30 P.M. alive and laying in bed. The nurse called for the other nurse on duty and told the CNA to move the resident from the bed to the floor and start CPR at approximately 9:55 P.M., while the nurse went to get the crash cart. The CNA contacted emergency medical services (EMS) at approximately 10:14 P.M. The LPN and CNA performed CPR on the resident until EMS arrived at approximately 10:22 P.M. and EMS took over CPR. EMS called the time of death at 10:42 P.M.

During an interview on 02/06/25, at 1:15 P.M., the Pharmacy Consultant said he/she completed monthly drug reviews at the facility. He/she did not see all new resident medications at the time of admission. The review would happen at the time of the next monthly review. He/she would look at the hospital discharge when able to. When reviewing resident charts, he/she would send a fax with any non-urgent recommendations every month. He/she would call the facility with urgent recommendations. He/she noted on the resident's chart that the Eliquis dose was higher than recommended for the patient's age, but not out of maximum dosing. He/she noted the diltiazem was at an extremely high dose and the maximum dose of the medication for any diagnosis was 540 mg daily. He/she contacted LPN D about the urgent need to change the medication. The pharmacy consultant checked later that day to ensure the change was made. He/she said that side effects of that dosage could include edema, bradycardia (slow heart rate), heart arrhythmia, and decreased blood pressure.

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During an interview on 02/06/25, at 1:25 P.M., LPN D on the day the resident was admitted he/she transcribed the medications from the hospital admission history and physical instead of the hospital discharge orders. He/she did not know when the physician saw the orders. He/she did notify the physician of the resident admission orders. He/She was notified from the pharmacy consultant 01/29/25 of the medication order correction. He/she then corrected the orders. He/she did not notify the physician of the incorrect orders. He/she thought the DON verified the order entries, but there was currently only an Interim DON and he/she did not know if the Interim DON was auditing charts.

During an interview on 02/06/25, at 11:00 A.M., Certified Medication Tech (CMT) A said if he/she had any concerns related to a medication order, he/she would talk to the charge nurse and the DON. If there was a medication error, it was to be reported to the charge nurse and DON. The nurse would contact the physician and the family. The resident was only at the home a short time. He/she took his/her medications without issue. When preparing and administering medications for residents he/she followed the orders in the MAR for medication administration. He/she was not aware of any medication error.

During an interview on 02/06/25, at 11:40 A.M., LPN C said the charge nurse entered the physician orders from the hospital discharge summary and notified the physician for approval before the resident received medications. Chart audits were done by management, but he/she did not know when that was completed. The pharmacy completed a medication review at least once per month. The pharmacy would send

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recommendations by fax and the nursing staff notified the physician to review the recommendations and make changes according to the physician's order. If there was a medication error, staff were to complete the medication error sheet, notify the DON and the physician, and follow any physician orders. He/she was not aware of any medication errors.

During an interview on 02/10/25, at 2:50 P.M., LPN E said that he/she usually was on the medication cart and the charge nurse was the one to enter orders for new admissions. Once the hospital sent the discharge summary the charge nurse would send it to the physician to review and to approve the orders. The nurse would enter the orders into the computer and he/she would help review the orders entered, when available. He/she said when entering orders a screen will pop up if there was a drug to drug interaction alert or other warning about the drug. The nurse had to sign off on that page when it popped up. He/she was not aware of any medication errors.

During an interview on 02/06/25, at 11:25 A.M., Registered Nurse (RN) B said when a new resident was admitted, the charge nurse on shift should enter the hospital discharge medication orders into the computer system and notify the physician for review. He/she would send the list to the pharmacy to fill the medications. Once the admission was completed, the DON or ADON completed chart audits. If notified of a medication error, he/she would notify the physician for orders, and notify the DON and Administrator. The nurse was not aware of any medication errors.

During an interview on 02/11/25, at 3:35 P.M.,

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LPN H said that when he/she received a new admission, he/she would look for the hospital discharge final orders and go through the orders with the resident being admitted, if the resident was alert, and verify that they seemed familiar to the resident. He/she would then verify the orders with the physician. Once the orders were entered into the computer, he/she would put the admission packet in the medical records box and was told that a copy was given to the administration staff to verify. If he/she was aware of a medication error, he/she would notify the physician and the family. He/she would monitor the resident for 72 hours and notify the physician of any issues. He/she would complete a risk management form, like an incident report. When he/she worked, if a CMT told him/her that something looked inaccurate on the MAR, he/she would thoroughly check into and investigate. He/she said it was not uncommon for him/her to find and fix errors. He/she was not aware of the resident receiving incorrect medication doses until after the fact.

During an interview on 02/10/25, at 4:30 P.M., LPN C and RN B both said the nurse getting the order from the physician would enter it into the electronic system in the POS. If the system detected a problem with the dosing amount/time, an allergy, or a conflict with another current medication, a warning message will pop up on the screen stating the information. The nurse should see the message before continuing. A warning symbol would then appear next to the medication on the POS. When administering medications, the warning does not pop up on the MAR, but the nurse or medication technician could check the warning box for the medication on the POS.

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During an interview on 02/06/25, at 11:50 A.M., the Interim DON said typically the charge nurse would put new physician orders into the computer and there would be a chart audit. The facility had gotten behind on chart audits. The nurse will now have the next shift nurse review the order entries because there had been some orders entered wrong. She was not aware of any outcome or medication errors due to the incorrect order entry. The resident was not expected to pass away, but was found unresponsive, CPR was initiated, and EMS contacted. She was not aware of any medication errors for resident.

During an interview on 02/06/25, at 2:15 P.M., the Corporate Nurse said the best practice for new resident admissions would be for the charge nurse to enter the orders from the hospital discharge summary and then to reconcile once entered into the computer. Staff should ask someone else to check their data entry of the orders. The interim DON should be doing chart audits.

During an interview on 02/06/25, at 2:40 P.M., the Medical Director said "that was an awful lot of diltiazem", when told of the dose provided. He/she said that dose was not a good thing. The side effects of that dose could include showing signs of hypotension.

During an interview on 02/06/25, at 1:55 P.M., the Administrator said when a charge nurse received a new resident admission he/she should review and enter the orders from hospital discharge summary. The physician visited with the new resident as soon as possible. She was not aware if staff were completing chart audits after new

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F 760	Continued From page 22 admission. The pharmacy consultant called the Corporate Nurse on 1/29/25 about the medication order entry for the resident. The Corporate Nurse came to the facility and went over the order entry process and medication error process with LPN D. The corrections were made to the resident's chart. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level "J". Based on observation, interview, and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of the exit 02/10/25, the severity of the deficiency was lowered to the "D" level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation." MO00249050	F 760		
F 843 SS=F	Transfer Agreement CFR(s): 483.70(i)(1)(2) §483.70(i) Transfer agreement. §483.70(i)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid	F 843		

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programs that reasonably assures that-
(i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and
(ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii).

§483.70(i)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a written transfer agreement with a hospital was in effect to ensure residents timely admission to the hospital when medically appropriate and that information would be exchanged between providers. This has the potential to effect all the residents. The facility census was 74.

Review showed the facility did not provide a policy pertaining to written transfer agreements with a hospital or a written transfer agreement with a community hospital.

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F 843	Continued From page 24 During interviews on 02/10/25, at 1:30 P.M. and 2:10 P.M., the Regional Director of Operations said he/she was not aware of the federal requirement for the facility to have a written transfer agreement with a hospital. Staff could not locate a written transfer agreement with a hospital. During an interview on 02/10/25, at 2:00 P.M., the Regional Nurse Consultant (RNC) said he/she was unaware of the federal requirement for a written transfer agreement with one or more hospitals. The RNC said the facility made a determination on which hospital to send a resident to based on the specific medical condition and the hospitals had always accepted their residents. During an interview on 02/10/25, at 5:00 P.M., the Administrator said he/she had not been able to locate a written transfer agreement.	F 843		

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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 I* Please refer to F760. *The higher classification merited due to the extent of the violation and the violations effect on the resident. NOTE: At the time of the complaint investigation, the violation was determined to be at an imminent danger class I level. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the class II level. 2. Class II Please refer to F658. MO00249050	A4055		
A4060	19 CSR 30-85.042(51) Medication Errors/Adverse Reactions Reported All medication errors and adverse reactions shall be reported immediately to the nursing supervisor	A4060		

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A4060	Continued From page 1 and the resident's physician and, if there was a dispensing error, to the issuing pharmacist. II/III This regulation is not met as evidenced by: Class II* Please refer to F760. *The higher classification merited due to extent of violation and violation's effect on the resident. MO00249050	A4060		

PLAN OF CORRECTION

Provider/Supplier Name:	Clinton Healthcare and Rehabilitation Center
Street Address, City, Zip:	1009 East Ohio Clinton, MO 64735
Date of Survey:	2/10/25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265255

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 prepared and executed because it is required by the provisions of the state and federal regulations and not because Clinton Healthcare and Rehabilitation Center agrees with the allegations and citations listed on the statement of deficiencies. Clinton Healthcare and Rehabilitation Center maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulation. This plan of correction shall operate as Clinton Healthcare and Rehabilitation's written credible allegation of compliance. By Submitting this plan of correction, Clinton Healthcare and Rehabilitation Center does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Clinton Healthcare and Rehabilitation Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action, or proceeding.	
F 658	Resident #2 had no adverse effects and/or negative outcomes from the alleged deficient practice. Resident #2 will have a comprehensive chart review and medication reconciliation completed by the compliance date. A comprehensive order review will be completed on facility residents to validate that appropriate orders have been transcribed. This will be completed by the compliance date. Facility residents have the potential to be affected by the alleged deficient practice. Education will be provided to Registered and Licensed Nurses and Certified Medication Technicians by the Regional Nurse Consultant and/or Designee on the following: • verification of admission orders, • transcription of admission orders, • identification factors of medication interactions,	3/17/2025

	• Appropriate identification of potential adverse consequences such as allergies, and physician notification responsibility. This will be completed by the compliance date and ongoing to validate competency and compliance. Newly admitted residents will have a comprehensive chart review completed within 24 hours of admission by a Registered Nurse. This extensive chart review will include a review to validate accurate medication transcription, appropriate dose, and appropriate identification of potential adverse consequences and allergies. Should concerns be identified, they will be addressed at the time of discovery. This will be completed daily x3 weeks, 2-3 times per week x3 weeks, weekly x3 weeks and then ongoing review will be completed for validation of continued compliance. New admission charts and the completed chart review will be reviewed at clinical meetings a minimum of 3-5 times per week x4, a minimum of 1-3 times per week x4, and ongoing to validate continued compliance. Audit findings will be reviewed at the monthly Quality Assurance and Performance Improvement meeting monthly x3, quarterly x3, and monthly ongoing until deemed no longer necessary by the committee. Areas of concern will be addressed at the time of discovery through re-education and evaluation for further intervention.	
F 760	Resident #1 is no longer at the facility. Facility residents have the potential to be affected by the alleged deficient practice. Facility Staff will have medication administration check off with staff who administrator medication on 2/06/25 and ongoing New admissions will be reviewed within 24 hours for medication reconciliation by the Director Of Nursing and/or Designee. Any medication error identified; the physician and family will be notified immediately and documented. Residents on hypotensive &/or hypertensive medications will be monitored by physician orders and parameters.. Any medication error will be reviewed by the physician, pharmacist and Director of Nurses or Designee. Effective 2/06/25 new admissions will be reviewed by two nurses within 24 hours of admission. Chart review of residents newly admitted and residents requiring parameters started on 2/06/25 and ongoing	03/17/2025

	Abatement ongoing plan of correction: A medication reconciliation and medication-to-card audit was implemented on 2/07/25 and completed on 2/08/25 to validate medication physician order transcription accuracy with the medication administration record and the medication cards. This was completed by a Registered, Licensed Nurse and/or Certified Medication Technician. Medication reconciliation and medication-to-card audit will be completed by a Registered, Licensed Nurse and/or Certified Medication Technician to validate accurate medication compliance quarterly and ongoing to validate compliance. Education will be provided by the Director of Nursing and/or Designee on validating medication reconciliation of newly/ readmitted resident orders, reconciling medication at the time of delivery from the pharmacy, and reporting to the Director of Nursing, Administrator, and physician any identified irregularities. This will be completed by the compliance date. Audit findings will be reviewed at the monthly QAPI meeting, monthly x3, quarterly x3 and ongoing until deemed no longer necessary by the committee. Areas of concern will be addressed at the time of discovery through re-education and evaluation for further intervention.	
F 843	No residents were directly identified to have been affected by this alleged deficient practice. Facility residents have the potential to be affected by the alleged deficient practice. Education will be provided by the Regional Director of Operations to the Administrator and Director of Nursing on validating that the facility has a written transfer agreement with a hospital for timely admission to the hospital when medically appropriate and that the information would be exchanged between providers. This will be completed by the compliance date. The facility will obtain a written transfer agreement by the compliance date. Validation of a written transfer agreement will be completed quarterly x3, and annually ongoing to validate continued compliance. Quarterly x3, the written transfer agreement will be reviewed at the monthly QAPI meeting, this will be done annually thereafter to validate ongoing compliance. Areas of concern will be addressed at the time of discovery through re-education and evaluation for further intervention.	03/17/2025

A4055	Refer to F760	03/17/2025
A4060	Refer to F658 , F760	03/17/2025

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.

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	265255	A. BUILDING _____ B. WING _____	R-C 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HEALTHCARE AND REHABILITATION CENTER	1009 EAST OHIO CLINTON, MO 64735

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F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to promote and facilitate each residents right to self-determination when staff failed to honor four residents' (Resident #1, #2, #3, and #4) shower preferences. The facility census was 71.	F 561		

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

Wanda Wilson | HSM | 4/11/25

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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Review of the facility's policy titled "Bath, Shower/Tub," dated February 2018, showed the following information:
-The purpose of the procedure was to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin;
-Document the date and time the shower/tub bath was performed;
-Document the name and title of the individual who assisted the resident;
-Document all assessment data obtained during the shower/tub bath;
-Document if the resident refused the shower/tub bath and the reason;
-Notify the supervisor if the resident refused the shower/tub bath.

1. Review of Resident #1's face sheet (brief information sheet about the resident) showed the following:
-Admission date of 07/22/20;
-Diagnoses included multiple sclerosis (chronic, autoimmune disease that affects the central nervous system (brain and spinal cord)), spastic hemiplegia (paralysis or severe weakness) affecting left dominant side on the left side of the body, chronic pain syndrome, and anxiety disorder.

Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 03/03/25, showed the following:
-Cognitively intact;
-Resident was totally dependent on staff for showering, toileting hygiene, and lower body dressing;
-Resident required substantial to maximal assistance of staff for upper body dressing and

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personal hygiene.

Review of the resident's nursing progress notes dated 03/03/25, at 5:26 P.M., showed the resident was totally dependent on staff for toileting and bathing, and substantial assistance to dependent on staff for dressing and grooming. Due to his/her impairment the resident required total assistance for mobility in bed and transfers. He/she was unable to ambulate.

Review of the resident's care plan, last updated 03/17/25, showed staff did not care plan regarding the resident's need for shower assistance and his/her shower preferences.

Review of the facility's shower sheets titled "Skin Monitoring: Comprehensive Certified Nurse Aide (CNA) Shower Review," showed the following:
-On 03/05/25, staff documented resident received a shower, fingernail care, and shaved. Staff stripped off the resident's linen, wiped down bedding, and made bed with clean linen. Staff noted no new skin concerns. A CNA and licensed practical nurse (LPN) signed the form.
-On 03/18/25 (13 days after prior shower), staff documented resident received a shower and shaved. Fingernail care was not needed. Staff stripped off bed linen, wiped down bed, and made bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form.

Review of the resident's record, on 03/26/25, showed no additional showers and no shower refusals.

Observation and interview on 03/26/25, at 10:20 A.M., showed the resident was in his/her bed. He/she said Tuesday and Friday were his/her

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scheduled shower days. His/her last shower was over one week ago. Before last week it had been over two weeks since his/her last shower. He/she felt terrible, dirty, and worried about smell without a shower twice per week.

2. Review of Resident #2's face sheet, showed the following:
-Admission date 05/08/23;
-Diagnoses included atrial fibrillation (condition where the upper chambers of the heart (atria) beat irregularly and rapidly), glaucoma (condition of increased pressure within the eyeball, causing gradual loss of sight), need for assistance with personal care, and muscle weakness.

Review of the resident's quarterly MDS, dated 12/20/24, showed the following:
-Moderate cognitive impairment;
-Resident required partial to moderate assistance of staff for showering, toileting hygiene, lower body dressing, upper body dressing and personal hygiene.

Review of the resident's care plan, updated 12/20/24, showed staff did not care plan related the resident's need for assistance with showers or shower preferences.

Review of the facility's shower sheets titled "Skin Monitoring: Comprehensive CNA Shower Review," showed the following:
-On 03/02/25, staff documented resident received a shower and fingernail care was not provided. Staff stripped off bed linen, wiped down bed, and made bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form;
-On 03/05/25, staff documented resident received a shower and fingernail care was not provided.

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Staff stripped off bed linen, wiped down bed, and made bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form;
-On 03/12/25 (seven days after prior shower), staff documented resident received a shower and fingernail care was not provided. Staff stripped off bed linen, wiped down bed, and made bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form.

Review of the resident's record, on 03/26/25, showed no additional showers and no shower refusals.

Observation and interview on 03/26/25, at 11:25 A.M., showed the resident was seated in his/her recliner. He/she said his/her last shower was over two weeks ago. He/she was offered a shower before his/her leg was broken, but it was going to be done by a man, and he/she did not want a man to complete the shower. He/she wrote dates down when he/she a shower, but was unable to find the last date. He/she felt dirty without being shower routinely.

3. Review of Resident #3's face sheet, showed the following:
-Admission date 10/04/24;
-Diagnoses included rhabdomylosis (medical condition characterized by the breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream), multiple fractures of ribs, muscle weakness, pain, and need for assistance with personal care.

Review of the resident's quarterly MDS, dated 01/06/25, showed the following:
-Moderate cognitive impairment;
-Resident was totally dependent on staff for

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toileting hygiene;
-Resident required staff assistance for set up or clean up of personal hygiene;
-Resident required partial to moderate assistance for upper body dressing;
-Resident required substantial to maximal assistance for showering and lower body dressing.

Review of the resident's care plan, updated 01/21/25, showed the following:
-Resident required assistance with activities of daily living (ADL's) related to limited mobility and pain;
-Resident required dependent to max assistant with shower transfers and full body showering;
-Resident required max to dependent assist of two staff for transfer to/from toilet, dependent for toilet hygiene and clothing management, and incontinent care of bowels. Resident had Foley catheter (a tube that is inserted into the bladder, allowing urine to drain freely) and dependent for catheter care.

Review of the facility's shower sheets titled "Skin Monitoring: Comprehensive CNA Shower Review," showed the following:
-On 03/03/25, staff documented resident received a shower and fingernail care. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form;
-On 03/06/25, staff documented resident received a shower and fingernail care was refused. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form;
-On 03/13/25 (7 days after prior shower), staff

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documented resident received a shower and toenail care was not provided. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form.

Review of the resident's record, on 03/26/25, showed no additional showers and no shower refusals.

Observation and interview on 03/26/25, at 10:52 A.M., showed the resident was in his/her wheelchair near the nursing station. The resident said he/she usually received a shower twice per week, but was unsure when he/she last received a shower. He/she really liked when he/she did receive a shower twice per week.

4. Review of Resident #4's face sheet, showed the following:
-Admission date 09/07/18;
-Diagnoses included cerebral infarction (stroke), hemiplegia (complete paralysis on one side of the body) and hemiparesis (milder form of weakness on one side) affecting unspecified side, anxiety disorder, and chronic pain syndrome.

Review of the resident's quarterly MDS, dated 01/20/25, showed the following:
-Cognitively intact;
-Resident was totally dependent on staff for toileting hygiene;
-Resident required substantial to maximal assistance for showers and lower body dressing;
-Resident required set up or clean up assistance from staff for upper body dressing;
-Resident required supervision or touching assistance from staff for personal hygiene.

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F 561	Continued From page 7 Review of the resident's care plan, updated 01/21/25, staff did not care plan regarding shower assistance or the resident's shower preferences. Review of the facility's shower sheets titled "Skin Monitoring: Comprehensive CNA Shower Review," showed the following: -On 03/03/25, staff documented resident received a shower and fingernail and toenail care provided. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form; -On 03/06/25, staff documented resident received a shower and fingernail care. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form; -On 03/10/25, staff documented resident received a shower and fingernail care not needed. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form; -On 03/17/25 (seven days after prior shower), staff documented resident received a shower and fingernail care not provided with toenail care provided by podiatrist. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form; -On 03/24/25 (seven days after prior shower), staff documented resident received a shower and fingernail care not provided with toenail care provided by podiatrist. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form.	F 561		

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F 561	Continued From page 8 Review of the resident's record, on 03/26/25, showed no additional showers and no shower refusals. Observation and interview on 03/26/25, at 11:00 A.M., showed the resident in his/her room in a wheelchair. The resident said he/she was only getting one shower per week, but preferred two per week. He/she a shower this Monday, 03/24/25, but felt it was only because he/she had a doctor's appointment. He/she was embarrassed when he/she had not received a shower and especially embarrassed to go to the doctor without a shower. The shower aide was frequently being pulled to work the floor. 5. During an interview on 03/26/25, at 10:00 A.M., CNA E said that there was only one shower aide that was not working this day. He/she said very few residents were receiving two showers per week. During an interview on 03/26/25, at 1:40 P.M., CNA C said that he/she was not told that any residents needed a shower. There was one shower aide and that he/she was not working this day. The shower aide had the shower schedule. During an interview on 03/26/25, at 11:20 A.M., LPN A said residents were not receiving showers twice per week. One shower aide recently quit and there was only one shower aide for the entire facility. During an interview on 03/26/25, at 11:35 A.M., LPN B said there was currently only one shower aide in the facility, but there was no one working as a shower aide this day. The residents were not receiving two showers per week.	F 561		

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F 561	Continued From page 9 During an interview on 03/26/25, at 1:55 P.M., LPN D said he/she knew that residents were not receiving showers twice per week. There was only one shower aide for the facility and the aide was not working this day. During an interview on 03/26/25, at 2:15 P.M., the Assistant Director of Nursing (ADON) said there was a recent turn over and only one full time shower aide was working. He/she called in on this day. Until another shower aide could be hired or assigned, the home planned to start having the floor aides provide showers as well. During an interview on 03/26/25, at 2:20 P.M., the Director of Nursing (DON) said the expectation was for residents to receive two showers per week and if a resident refused a shower they would have to sign the shower sheet.	F 561		
	MO00251410, MO00251648			
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to protect each resident's right to be free from misappropriation of proper when narcotic	F 602		

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pain medications for one resident (Resident #3) went missing while in the possession of the facility staff. The facility census was 71.

Review of the facility's policy titled "Administering Pain Medications," dated October 2022, showed the following:
-Document in the resident's medical record results of the pain assessment, medication, dose, route of administration, and results of the medication;
-Report other information in accordance with facility policy and professional standards of practice.

Review of the facility's policy titled "Medication Orders," dated February 2023, showed the following:
-Medications included in the Drug Enforcement Administration (DEA) classification of controlled substances (drug or chemical whose manufacture, possession, and use are regulated by a government), and mediation classified as controlled substance by state law, are subject to special ordering, receipt, and record keeping requirements in the facility, in accordance with federal and state laws and regulations;
-Before a controlled drug can be dispensed, the pharmacy must be in receipt of a prescription from a person lawfully authorized to prescribe;
-The Director of Nursing (DON) and the contracted consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications;
-Only authorized, licensed nursing and pharmacy personnel have access to controlled medications;
-Controlled substance medications are dispensed by the provider pharmacy in readily accountable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265255	A. BUILDING _____ B. WING _____	R-C 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HEALTHCARE AND REHABILITATION CENTER	1009 EAST OHIO CLINTON, MO 64735

(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 602	Continued From page 11	F 602		

quantities and containers designed for easy counting of contents;
-The pharmacy will include an individual resident controlled drug record (count sheet) for each controlled substance medication container dispensed to a resident if the facility so desires;
-Alternatively, the facility may utilize a bound book in place of count sheets;
-The following information is completed up dispensing or upon receipt of the controlled substance: resident's name, prescription number, drug name, strength, and dosage for of medication, date received, quantity received, and the name of person receiving the medication supply;
-If the facility uses a bound book in lieu of the pharmacy count sheets, all of this information will be completed by a licensed nurse at the facility;
-At each change of custody (shift change or exchange of keys) all on-hand controlled medication quantities shall be counted by two nurses and reconciled with the count sheets;
-This shall be documented by completing a Controlled Drug Count Form indicating the date and time the physical count was completed;
-Any discrepancies shall be reported to the charge nurse and the DON immediately;
-With the nurse supervisor present, the discovering nurse should place a signed entry on the resident controlled drug record where the discrepancy was detected;
-If it is something other than a mathematical error, the DON should provide assistance with the investigation and resolving the discrepancy;
-Controlled substance medications are stored at the facility under double lock on the medication cart or medication room separate from all other medications.

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1. Review of Resident #3's face sheet (brief information sheet about the resident) showed the following:
-Admission date of 10/04/24;
-Diagnoses included rhabdomyolysis (medical condition characterized by the breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream), multiple fractures of ribs, pain, muscle weakness, and osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down).

Review of the resident's care plan, dated 10/18/24, showed the following:
-Resident received as needed pain medication therapy related to rhabdoymyolysis, rib fractures, and occasional generalized pain;
-Staff should administered analgesic (pain) medications as ordered by physician;
-Staff should monitor and document side effects and effectiveness every shift;
-Staff should notify physician if medication does not control pain to tolerable level.

Review of the resident's Physician Order Sheet (POS), current as of 03/26/25, showed an order, dated 10/04/24, for morphine sulfate ER (drug used to treat moderate to severe pain), oral tablet extended release 30 milligrams (mg), give one tablet by mouth two times per day for multiple fracture of ribs.

Review of the resident's March 2024 Medication Administration Record (MAR), showed staff documented administration of morphine sulfate ER 30 mg every day in the morning and at bedtime from 03/01/25 to 03/26/25.

Review of the pharmacy consolidated delivery

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sheets, dated 03/10/25, showed morphine sulfate ER 30 mg tablets, quantity of 60 tablets, received for the resident.

Review of the controlled medication logbook on the medication cart showed the following:
-On 03/10/25, staff documented there was 9 tablets of morphine sulfate and the pharmacy delivered 60 tabs. The total at the end of shift was 69 tablets;
-On 03/16/25, the resident had 57 tablets of morphine sulfate. When the evening shift completed the change of shift count there were only 27 tablets of morphine sulfate in the cart;
-On 03/24/25, the pharmacy delivered 30 tablets of morphine sulfate;
-On 03/26/25, at 1:55 P.M., there were 38 tablets of morphine sulfate in the cart when reviewed with nurse.

Review of the facility's "Investigation Report," dated 03/18/25, showed the following information:
-On 03/16/25, at 10:10 P.M., the Administrator received a call from Licensed Practical Nurse (LPN) B that the narcotic count for the resident showed there was 30 tablets of morphine sulfate missing;
-Staff searched the medication cart and medication room. The medication was not located;
-Police department notified on 03/17/25;
-Notified pharmacy to report and request they send replacement for the missing medication and to bill the facility;
-LPN F's statement, dated 03/16/25, showed the LPN worked 4 ½ hour shift, from 5:30 P.M. to 10 P.M. The nurse was rushing during the count at the beginning of shift and was unsure if the count was actually correct at that time;

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F 602	Continued From page 14 -LPN A's statement, dated 03/17/25, showed he/she counted medications on beginning of shift on 03/15/25 evening and end of shift on 03/16/25 morning. The count was correct at those time. When he/she worked the day shift on 03/17/25, he/she was informed by the night shift nurse that the count was off by 30 tablets. During an interview on 03/26/25, at 10:45 A.M., LPN A said the narcotic count was completed at the beginning and end of every shift. If the count was incorrect staff should notify the DON and administrator immediately. During an interview on 03/26/25, at 11:35 A.M., LPN B said the process for narcotics included the off-going nurse taking the narcotic book and the on-coming nurse taking the narcotic drawer to complete the shift count. Staff start by going through all of the tablets and then they count the liquids. If the narcotic count was not correct staff were to immediately contact the supervisor and staff do not leave the facility until the supervisor approved. During an interview on 03/26/25, at 1:55 P.M., LPN D said that if the log and tablets do not match during shift change, staff are to call management and have to stay at the facility until approved to leave. During an interview on 03/26/25, at 2:15 P.M., the Assistant Director of Nursing (ADON) said staff should complete a narcotic count during each shift change. If an error was found, staff were to contact management immediately. During an interview on 03/26/25, at 2:20 P.M., the DON said she expected the staff to follow facility	F 602		

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F 602	Continued From page 15 policy. During an interview on 03/26/25, at 2:40 P.M., the Administrator said when she was notified of narcotic count discrepancy on 03/16/25 around 10:00 P.M. by LPN B. The medication cart and medication room were searched, and the narcotic was not located. The nursing staff did not have any knowledge of where the narcotics could be. The Administrator expected staff to complete narcotic counts accurately with every shift change. If the count was not accurate the staff were to notify the DON and Administrator immediately for further instructions. MO00251335	F 602		

Missouri Department of Health and Senior Services

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	01318	A. BUILDING: _____ B. WING _____	R-C 03/26/2025

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A4071	19 CSR 30-85.042(62) Controlled Substance Reconcile/Record The facility must establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. The system must enable the facility to determine that drug records are in order and that an account of all controlled drugs is maintained and reconciled. II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F602. *The higher classification merited due to the extent of the violation. MO00251335	A4071		
A4077	19 CSR 30-85.042(68) Res Groomed/Dressed Appropriately Taking into consideration the resident's preferences, residents shall be well-groomed and dressed appropriately for the time of day, the environment and any identified medical conditions. II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F561. *The higher classification merited due to the extent of the violation and impact on the residents. MO00251410, MO00251648	A4077		

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A8023	Continued From page 1	A8023		
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F602. *The higher classification merited due to the extent of the violation. MO00251335	A8023		

PLAN OF CORRECTION

Provider Name:	Clinton Healthcare Center
Street Address, City, Zip:	1009 E Ohio St. Clinton Mo 64735
Date of Survey:	03/26/2025
Provider number:	265255

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 prepared and executed because it is required by the provisions of the state and federal regulations and not because Maywood Terrace Living Center agrees with the allegations and citations listed on the statement of deficiencies. This plan of correction shall operate as Maywood Terrace Living Center written credible evidence of compliance.	
F602 D	Resident # 3 had no actual harm from the incident. The medication was replaced from pharmacy and the facility was billed for the medication. The physician and family were notified of the incident. Addendum to this element on 4/16/25 WWilson RN/ADM	04/14/2025
	All facility residents have the potential to be affected by this alleged deficient practice.	
	Education will be provided by Regional Nurse Consultant and/or Director of Nursing to all Licensed Nurses and CMT's on the following: Policy and Procedure for Controlled Substances, process for signing for medications upon receipt from Pharmacy, narcotic count at change of shift, notification to DON immediately if narcotic count is off, Controlled substance storage.	

	The Director of Nursing and/or designee will conduct audits to validate Controlled Substance Policy and Procedures are being followed, medications are signed for upon delivery by Pharmacy and the correct process is followed, narcotic count done and signed off at change of shift and controlled substance storage policy is followed. This will be completed 5x week for 1 week, 3x week for 2 weeks and 1x week monthly until substantial compliance is met.	
	Audit findings will be reviewed at the monthly QAPI meeting to ensure plan compliance and measurable outcomes. Plans of action will be augmented as indicated by the QAPI plan, with education directed as applicable.	
F561 E	The residents identified, #1, #2, #3, #4, have had the opportunity to update their shower/bath preferences and their plans of care have been updated to indicate their preferences, as well as their shower schedules	04/14/2025
	All residents can be impacted by the alleged deficient practice. The facility will conduct an audit of all residents to identify those who require assistance with showers.	
	Conduct shower preference interviews with residents identified. Update care plans to reflect the specific needs and preferences of each resident regarding shower frequency and assistance. Provide training to all nursing staff on the importance of maintaining personal hygiene for residents, including proper showering techniques and frequency. DON or Designee to review all bath sheets and schedules daily to ensure that baths have been provided according to schedule. Any resident who refuses to bathe will be documented as such. This will be done 5x week for 1 week, 3x week for 2 weeks, then weekly ongoing. Audits will be reviewed by the Administrator weekly in oversite of the Director of Nursing.	

	Audit findings will be reviewed at the monthly QAPI meeting to ensure plan compliance and measurable outcomes. Plans of action will be augmented as indicated by the QAPI plan, with education directed as applicable.	
A8023	Refer to F602	04/14/2025
A4077	Refer to F561	04/14/2025
A4071	Refer to F602	04/14/2025

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.