STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265877	A. BUILDING _____ B. WING _____	C 12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTGATE	3130 JOHN DUFFY DR JOPLIN, MO 64804

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish a system of record keeping to ensure all controlled substances (substances that have an accepted medical use (medications	F 755	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Misty Caldwell, RN/ADM — TITLE: Administrator — (X6) DATE: 1/23/25

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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which fall under US Drug Enforcement Agency (DEA) Schedules II-V), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) were accurately accounted for when staff did not accurately document all administrations of and could not easily reconcile the balance of a controlled medication for one resident (Resident #1) out of four sampled residents. The facility census was 110.

The facility Administrator and the Assistant Director of Nursing (ADON) were notified of the Past Non-Compliance which occurred on 11/28/24. The facility staff began an investigation on 12/12/24 when the medication reconciliation error was found. The facility began immediate in-servicing of all staff who were on-site and as they arrived for work prior to beginning their shift. The facility also notified the Department of Health and Senior Services (DHSS) and the local law enforcement agency of the event. The facility completed medication audit, drug testing of staff who had access to controlled substances, and implemented additional medication procedures. The noncompliance was corrected on 12/12/24.

Review of the facility's policy titled "Controlled Substances," revised 11/2022, showed the following:

-The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976);
-Only authorized licensed nursing and/or pharmacy personnel have access to Schedule II

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controlled
substances maintained on premises;
-Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record;
-If the count is correct, an individual resident controlled substance record is made for each resident who will be receiving a controlled substance. Do not enter more than one prescription per page. This record contains: name of the resident, name and strength of the medication, quantity received, number on hand, name of prescriber, prescription number, name of issuing pharmacy, date and time received, time of administration, method of administration, signature of person receiving medication, and signature of nurse administering medication;
-Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up;
-The system of reconciling the receipt, dispensing, and disposition of controlled substances includes the records of personnel access and usage; medication administration records, declining inventory records and destruction, waste; and return to pharmacy records;
-Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count;
-The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services;
-The Director of Nursing Services (DON)

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documents irreconcilable discrepancies in a report to the Administrator;
-If a major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity, the
DON notifies the Administrator and consultant pharmacist immediately;
-The Administrator, consultant pharmacist, and/or DON determine whether other action(s) are needed, e.g., notification of police or other enforcement personnel;
-The medication regimen of residents using medications that have such discrepancies are reviewed to
assure the resident has received all medications ordered and the goal of therapy is met (example: a
resident receiving a pain medication complains of unrelieved pain);
-The DON consults with the provider pharmacy and the Administrator to determine whether any further legal action is indicated.

1. Review of Resident #1's face sheet (a document that gives a patient's information at a quick glance)showed the following:

-Admission date of 09/11/24;
-Diagnoses included chronic respiratory failure with hypoxia (a condition where the lungs are unable to adequately exchange oxygen and carbon dioxide over a prolonged period, resulting in persistently low levels of oxygen in the blood (hypoxia) due to impaired lung function), pneumonia, and heart failure.

Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated

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F 755	Continued From page 4 12/18/24, showed the following: -The resident was cognitively intact; -The resident received scheduled and as needed (PRN) pain medications and non-medication interventions for pain; -The resident occasionally had pain; -The resident's pain occasionally effected the resident sleep and interfered with therapy and day to day activities; -The resident rated his/her pain at 4 on a scale of 0 to 10. Review of the resident's care plan, revised 12/10/24, showed the resident had acute and chronic pain related to chronic back pain. Interventions included staff to evaluate the resident's pain. Review of the resident's December 2024 Physician's Order Sheet (POS) showed the following: -An order, dated 10/14/24, for morphine sulfate (a prescription opioid analgesic drug that treats moderate to severe pain) oral solution 20 milligrams (mg)/milliliter (ml). Staff to administer .5 ml by mouth every two hours as needed for anxiety or air hunger (a sensation of shortness of breath or difficulty breathing). Review of the resident's November 2024 Medication Administration Record (MAR) showed on 11/27/24, at 9:17 P.M., the staff administered .5 ml morphine sulfate. Review of the resident's controlled drug record for morphine sulfate showed on 11/27/24, at 9:17 P.M., staff administered .5 ml with a balance of	F 755		

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F 755	Continued From page 5 40 ml. Review of the resident's November 2024 MAR showed on 11/28/24, at 10:55 P.M., the staff administered .5 ml morphine sulfate. Review of the resident's controlled drug record for morphine sulfate showed on 11/28/24, at 10:55 P.M., staff administered .5 ml with a balance (that was written over several times) of 39.5 ml (unable to determine the original documented balance). Review of the resident's November 2024 MAR showed on 11/29/24, at 5:33 A.M. and 9:05 P.M., staff administered .5 ml. morphine sulfate. Review of the resident's controlled drug record for morphine sulfate showed the following: -On 11/29/24, at 5:33 A.M., staff administered .5 ml with a balance (that was written over several times) of 39 ml (unable to determine the original documented balance); -On 11/29/24, at 9:05 P.M., staff administered, .5 ml with a balance (that was written over several times) of 38.5 ml (unable to determine the original documented balance). Review of the resident's December 2024 MAR showed on 12/01/24, at 4:00 P.M., staff administered .5 ml morphine sulfate. Review of the resident's controlled drug record for morphine sulfate showed on 12/01/24, at 4:00 P.M., staff administered .5 ml with a balance (that was written over several times) of 38 ml (unable to determine the original documented balance). Review of the resident's December 2024 MAR	F 755		

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F 755	Continued From page 6 showed on 12/02/24, at 8:57 P.M., staff administered .5 ml morphine sulfate. Review of the resident's controlled drug record for morphine sulfate showed on 12/02/24, at 9:00 P.M., staff administered .5 ml with a balance (that was written over several times) of 37.5 ml (unable to determine the original documented balance). Review of the resident's December 2024 MAR showed on 12/03/24, at 9:27 P.M., staff administered .5 ml morphine sulfate. Review of the resident's controlled drug record for morphine sulfate showed on 12/03/24, at 9:28 P.M., staff administered .5 ml with a balance (that was written over several times) of 37 ml (unable to determine the original documented balance). Review of the resident's December 2024 MAR showed staff did not document administration of the resident morphine sulfate on 12/04/24. Review of the resident's controlled drug record for morphine sulfate showed on 12/04/24, at 10:00 P.M., staff administered .5 ml given with a balance (that was written over several times) of 36.5 ml(unable to determine the original documented balance). Review of the resident's December 2024 MAR showed staff did not document administration of the resident morphine sulfate on 12/05/24. Review of the resident's controlled drug record for morphine sulfate showed the following: -On 12/05/24, at 1:30 A.M., staff administered .5 ml with a balance (that was written over several	F 755		

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times) of 36 ml (unable to determine the original documented balance);
-On 12/05/24, at 10:00 P.M., staff administered .5 ml with a balance (that was written over several times) of 35.5 ml (unable to determine the original documented balance).

Review of the resident's December 2024 MAR showed on 12/06/24, at 8:43 P.M., staff administered .5 ml morphine sulfate. (Staff did not document a second dose administered.)

Review of the resident's controlled drug record for morphine sulfate showed the following:

-On 12/06/24, at 1:00 A.M., staff administered .5 ml with a balance (that was written over several times) of 35 ml (unable to determine the original documented balance);
-On 12/06/24, at 9:00 P.M., staff administered .5 ml. with a balance (that was written over several times) of 34.5 ml (unable to determine the original documented balance).

Review of the resident's December 2024 MAR showed on 12/07/24, at 9:17 P.M., staff administered .5 ml morphine sulfate. (Staff did not document a second dose administered.)

Review of the resident's controlled drug record for morphine sulfate showed the following:

-On 12/07/24, at 2:00 P.M., staff administered .5 ml with a balance (that was written over several times) of 34 ml (unable to determine the original documented balance);
-On 12/07/24, at 9:00 P.M., staff administered .5 ml given with a balance of 29.5 ml. The balance had a single line through it and new balance of

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F 755	Continued From page 8 33.5 ml written in. Review of the resident's December 2024 MAR showed on 12/08/24, at 9:34 P.M., staff administered .5 ml morphine sulfate. (Staff did not document a second dose administered.) Review of the resident's controlled drug record for morphine sulfate showed the following: -On 12/08/24, at 1:45 A.M., staff administered .5 ml with a balance of 29 ml. The balance had a single line through it and new balance of 33 ml written in; -On 12/08/24, at 9:00 P.M., staff administered .5 ml with a balance of 28.5 ml. The balance had a single line through it and new balance of 32.5 ml written in. Review of the resident's December 2024 MAR showed on 12/09/24, at 9:07 P.M., staff administered .5 ml morphine sulfate. Review of the resident's controlled drug record for morphine sulfate showed on 12/09/24, at 9:00 P.M., staff administered .5 ml. with a balance of 28 ml. The balance had a single line through it and new balance of 32 ml written in. Review of the resident's December 2024 MAR showed staff did not document administration of the resident morphine sulfate on 12/10/24. Review of the resident's controlled drug record for morphine sulfate showed on 12/10/24, at 6:00 A.M., staff administered .5 ml. with a balance of 27.5 ml. The balance had a single line through it and new balance of 31.5 ml written in.	F 755		

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Review of the resident's December 2024 MAR showed on 12/11/24, at 10:24 P.M., staff administered .5 ml morphine sulfate. (Staff did not document a second dose administered.)

Review of the resident's controlled drug record for morphine sulfate showed the following:

-On 12/11/24, time illegible, staff administered .5 ml with a balance of 27 ml. The balance had a single line through it and new balance of 31 ml written in;
-On 12/11/24, at 9:30 P.M., staff administered .5 ml. with a balance of 26.5 ml. The balance had a single line through it and new balance of 30.5 ml written in.

Review of the resident's December 2024 MAR showed on 12/12/24, at 1:35 A.M. and 9:47 P.M., staff administered .5 ml morphine sulfate.

Review of the resident's controlled drug record for morphine sulfate showed the following:

-On 12/12/24, at 1:30 A.M., staff administered .5 ml. with a balance of 26 ml. The balance had a single line through it and new balance of 30 ml written in.;
-On 12/12/24, 26 ml of morphine sulfate was destroyed (a discrepancy of 4 ml).

Review of the facility's investigation, received by Department of Health and Senior Services (DHSS) on 12-17-24, showed the following:

-Narcotic count reviewed by Licensed Practical Nurse (LPN) B on 12/12/24, at approximately 8:00 A.M. Incorrect documentation was noted in narcotic count for morphine sulfate on 11/27/24.

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Documentation recorded 35.5 ml and the correct documentation was 39.5 ml. The Assistant Director of Nursing (ADON) was notified and reviewed the documentation. The medication was destroyed and medication was then pulled from the emergency kit. The resident did not miss any doses of medication;
-On 12/12/24, at 6:37 P.M., the facility notified Joplin Police Department;
-On 12/12/24, at 6:47 P.M., staff notified the medical director;
-The DON was unable to determine a cause of the missing medication due to insufficient information;
-A written statement from LPN B, dated 12/12/24, showed he/she noticed at approximately 8:00 A.M. that there was an error in the documentation with the morphine count start on 11/27/24. He/she notified the ADON and he/she and the ADON then corrected the documentation. The ADON then notified the DON.

During an interview on 12/31/24, at 9:52 A.M., Certified Medication Technician (CMT) A said licensed nurses passed narcotics at the facility. If he/she noticed missing medications, he/she first looked in the medication room and then notified the charge nurse if he/she could not find them.

During interviews on 12/31/24, at 11:39 A.M. and 1:06 P.M., LPN B said the following:

-On 12/12/24, he/she noticed a discrepancy in the resident's count of morphine sulfate in the narcotic book. A nurse deducted 1 ml when they should have deducted .5 ml;
-He/she immediately reported this to the ADON;
-He/she and the ADON looked and found the error and attempted to correct the count;

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F 755	Continued From page 11 -He/she should have drawn a single line through the original documentation and initialed it with two nurses, then wrote the correct amount out to the side; -He/she did not do this because there was not much room on the form; -Other nurses should have found the discrepancy earlier if they completed the count correctly and actually laid eyes on the bottle of medication; -He/she did not know if the resident's medication was accounted for. -When nurses completed shift change, they completed a count of the narcotics; -One nurse counts the medication while the other nurse verifies the amount in the narcotic log; -If a resident had two bottles of morphine sulfate opened, he/she used out of the bottle with the least amount first; -Nurses should not combine bottles of medication because this could cause the count to be inaccurate if they could not get all of the liquid out of the bottle. The ADON educated him/her on this and controlled medication procedures when the discrepancy was found. During interviews on 12/31/24, at 11:54 A.M. and 1:09 P.M., LPN C said the following: -When nurses completed shift change, they counted controlled medications together; -One nurse counts the medication and the other compares against the narcotic book; -If he/she noticed a discrepancy, he/she notified the DON immediately and did not accept the cart until it was resolved; -If an error was made in the narcotic log, he/she put a single line through the original documentation and the correct documentation to the side. Two nurses initialed this;	F 755		

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F 755	Continued From page 12 -If a resident had two open bottles of a liquid medication, he/she used from the bottle with less medication in it; -He/she never combined the medications because there was a risk of spillage or not getting all of the medication out of one bottle. Also, he/she was not a pharmacist; -If there was a discrepancy between the medication count and the narcotic book documentation, it should be noticed immediately and not take 15 to 16 days to notice if nurses completed the count correctly and actually laid eyes on the medication. During interviews on 12/31/24, at 9:08 A.M. and 1:14 P.M., the ADON said the following: -LPN B started correcting the resident's narcotic log when the LPN brought the log to him/her; -He/she told the LPN they needed to put a single line through the original documentation and the correct documentation out to the side and initial this; -When he/she took over, he/she completed the correction correctly; -He/she could not tell what the original documentation was from 11/28/24 through 12/07/24; -He/she did not know where the 4 ml of morphine sulfate went; -At shift change, nurses completed report and counted controlled substances; -The on-coming nurse counted the pills, liquids and patches and the off-going nurse verified the amount in the narcotic book; -If the nurses noticed a discrepancy, they notified the ADON or DON immediately to investigate and the on-coming nurse did not take control of the medication cart until it was resolved;	F 755		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTGATE	**3130 JOHN DUFFY DR JOPLIN, MO 64804**

(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 755	Continued From page 13 -If a resident had two open bottles of the same medication, the bottles were counted separately and had their own narcotic record; -Nurses should not combine the bottles because this could lead to an error in the count due to not being able to get all of the liquid out of the bottle. Also, they were not pharmacist; -Nurses should notice a discrepancy immediately if they completed the controlled substance count correctly. They should not take 15 to 16 days to notice a discrepancy. During an interview on 12/31/24, at 1:47 P.M., the Administrator said the following: -Nurses completed count of the controlled substances when they completed shift change; -Both nurses should go to the drawer, one nurse counted the medication and the other confirmed the amount on the narcotic log and both sign to verify the count was correct; -The nurses should look at the amount of liquid medication in the bottles; -The nurses should notice a discrepancy immediately and not 15 to 16 days later; -If the nurses noticed a discrepancy, they notified the ADON or DON immediately; -If a resident had two open bottles of liquid medication, they should not combine them because the medications could have different lot numbers and they were not pharmacists; -Each bottle of liquid medication should have it's own narcotic log. MO00246513	F 755		