

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33475	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/03/2025
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NAME OF PROVIDER OR SUPPLIER BOULEVARD SENIOR LIVING OF ST PETERS,	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BLUFFSTONE CIRCLE SAINT PETERS, MO 63304
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A4798	<p>19 CSR 30-86.047(47)(A) Physicians Orders Followed</p> <p>Medication Orders. (A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. II/III</p> <p>This regulation is not met as evidenced by: Class II*</p> <p>Based on interview and record review, the facility failed to follow physician's orders for one resident (Resident #1) with a history of blood clots, in a review of five sampled residents, when staff failed to obtain and administer Eliquis (prescription anticoagulant (blood thinner) used to treat and prevent blood clots) from the pharmacy for three days. The facility census was 66.</p> <p>Review of the facility policy for Medication Administration dated 8/5/25 showed the following: -Policy: to ensure medications are properly given, medication is to be administered as directed per physician orders; - Blood Thinners and Anticoagulants: Policy: to ensure residents on blood thinner and anticoagulant medications receive proper anticoagulant therapy and monitoring of routine labs; Procedures: residents should receive their blood thinner and anticoagulant medication according to physician's orders.</p> <p>1. Review of Resident #1's face sheet showed the resident admitted to the facility on 7/6/24 with diagnoses of dementia.</p> <p>Review of the resident's progress notes dated 9/12/25 showed the following: -At 8:36 A.M. call to responsible party to say the</p>	A4798		

Missouri Department of Health and Senior Services

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

TITLE

(X6) DATE

Windy Kemp

Executive Director

10-31-25

Missouri Department of Health and Senior Services

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A4798	<p>Continued From page 1</p> <p>resident was very sick. Responsible party called to say a family member would be at the facility to take the resident to the physician's office.</p> <p>-At 3:59 P.M. resident currently at local hospital emergency room and being admitted for pneumonia and abscess between shoulder blades.</p> <p>Review of the resident's discharge orders from the local hospital dated 9/15/25 showed the following:</p> <p>-Discharge diagnosis of pulmonary embolism and pneumonia;</p> <p>-Order for apixaban (Eliquis prescription anticoagulant (blood thinner) used to treat and prevent blood clots) 5 milligrams (mg) two tablets for a total of 10 mg two times a day for six days.</p> <p>Review of the resident's progress notes dated 9/15/25 6:55 P.M. signed by Licensed Practical Nurse (LPN) A showed the resident returned to the facility. Medication list was sent to the pharmacy.</p> <p>Review of the Medication Administration Record (MAR) dated September 2025 showed the following:</p> <p>-Eliquis 5 mg take two tablets twice (BID) a day for six days for blood clots documented as not administered on 9/15/25 for the evening dose.</p> <p>-Documented as given on 9/16/25 for the morning dose and documented as medication not available for the evening dose;</p> <p>-Documented as medication not available on 9/17/25 for the morning and evening dose;</p> <p>-Documented as medication not available on 9/18/25 for the morning dose and see progress notes for the evening dose.</p> <p>Review of the resident's progress notes dated</p>	A4798		

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A4798	<p>Continued From page 2</p> <p>9/18/25 at 12:37 P.M. showed the following: -Resident's responsible party notified of the Eliquis not being covered by his/her insurance and the need for authorization to have the medication filled. Verbal permission given by the responsible party; -Pharmacy notified of the authorization and will send the medication out with today's medications.</p> <p>Review of the resident's progress notes dated 9/20/25 at 1:31 P.M. showed the hospital called to get an update on why the resident was being sent to the hospital and checking on the administration of the Eliquis. The facility informed the hospital that the resident had not been given Eliquis and was having abnormal breathing.</p> <p>During an interview on 10/3/25 at 12:40 P.M. LPN A said the following: -He/She was the nurse who readmitted the resident on 9/15/25; -He/She received the resident's orders around 6:15 P.M. and sent the orders to the pharmacy via their internal system; -He/She reported the orders to the oncoming shift and was off duty at 7:00 P.M.; -He/She did not see a message or the form for the authorization for Eliquis.</p> <p>During an interview on 10/3/25 at 12:50 P.M. LPN B said the following: -He/She came on duty the following day and did not see the authorization form nor did he/she administer any medications for the resident; -He/She was not aware that the resident had orders for Eliquis and the medication was not available; -Medications are passed by either a Level One Medication Aide (LIMA) or a Certified Medication Aide (CMT);</p>	A4798		

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A4798	<p>Continued From page 3</p> <ul style="list-style-type: none"> -The pharmacy communicates with the nurses via a fax or through a messaging application on the phone; -He/She checked the fax machine several times a shift and does not recall any fax for the authorization and there was no message on the phone about needing an authorization for the medication; -The last message on the phone about the resident was on 9/15/25 that LPN A sent the orders to the pharmacy at 6:54 P.M. and this was verified by observing the messaging application on the phone; -The hospital sends the resident's medication orders directly to the facility pharmacy while the resident is in the hospital after the physician writes the discharge orders. Once the resident is back to the facility, the nurses will verify the orders and will also send the orders over to the pharmacy. <p>During an interview on 10/3/25 at 1:05 P.M. and 10/7/25 at 9:55 A.M. the pharmacy representative said the following:</p> <ul style="list-style-type: none"> -The pharmacy received the resident's medication orders from the local hospital at 4:33 P.M.; -The non-covered notice and the authorization form was sent to the facility on 9/15/25 at 5:33 P.M. and a message was sent with the non-covered notice and the authorization form attached via the messaging app at 5:35 P.M. -The pharmacy did not receive the authorization form until 9/18/25 and Eliquis was sent to the facility in the evening on 9/18/25. <p>During an interview on 10/7/25 at 10:45 A.M. LIMA C said the following:</p> <ul style="list-style-type: none"> -He/She passed medication to the resident on 9/16/25 and was aware that Eliquis was not 	A4798		

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A4798	<p>Continued From page 4</p> <p>available in the medication cart for several days; -He/She documented that the medication was not available; -He/She does not have a phone with the pharmacy messaging app; -He/She was unaware that the medication needed an authorization; -He/She was not aware of what Eliquis was until after the resident went to the hospital on 9/18/25; -He/She does not have access to the emergency medication kit; -Had he/she known what the medication was for on 9/16/25, he/she would have reported this to the nurse on 9/15/25.</p> <p>During an interview on 10/6/25 at 11:30 A.M. the DON said the following: -Nurses will get messages from the pharmacy on the messaging app on the phone, she also received the messages; -She did not open the message until several days later; -Pharmacy also will fax any needed paperwork and communications. Nurses are supposed to check the fax machine several times a day; -The non covered notice and authorization form was found on the nurses desk on 9/18/25 after the resident had went to the hospital; -She did not know who got the fax and placed it on the desk; -Eliquis was kept in the emergency medication kit and she did not know why staff did not pull the Eliquis from the emergency kit for administration.</p> <p>During an interview on 10/3/25 at 3:30 P.M. and 10/7/25 at 9:15 A.M. the Administrator said the following: -She became aware of the Eliquis not being administered when the resident's responsible party called her on 9/18/25 when the resident had</p>	A4798		

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A4798	<p>Continued From page 5</p> <p>been sent to the hospital; -She began an investigation and a photo was taken of the screen of the nurses phone that showed a message had been sent from the pharmacy on 9/15/25 at 5:35 P.M. informing them of the medication not being delivered and a non covered form and a authorization form had been attached. This message had also been sent to the Director of Nursing (DON) and a former Assistant Director of Nursing; -She does not know why the DON had not opened the message and does not know why the message is not showing up on the nurses phone; -The authorization form was found in the nurses office on 9/18/25 after the resident had been sent to the hospital; -She had the nurse call the responsible party and obtain authorization to have the medication filled. -If Eliquis was in the emergency kit, then the medication should have been administered; -She did not know who had access to the emergency medication kit; -She would expect all staff to follow physician orders and call the pharmacy if a medication was not available.</p> <p>*The higher classification merited due to the violation's effect on the resident.</p> <p>MO258521</p>	A4798		

	<p>Weekly Medication Cart Audits: The Wellness Director or designee will conduct weekly audits of the medication carts to confirm the accuracy of medications and corresponding physician orders. Any expired medications will be disposed of in accordance with community policy.</p> <p>Staff Education: The Wellness Director or designee will provide training for all medication administration staff on <i>The Five Rights of Medication Administration and Understanding Medication Labels, Orders, and Documentation</i>.</p> <p>Audit Results Reporting: The Wellness Director will present weekly audit results to the Executive Director (ED) during their scheduled one-on-one meetings for eight consecutive weeks following implementation of these procedures.</p>	
	<p>Monitoring for on-going compliance: The results from the weekly medication audits will be reviewed during the weekly Department Head meetings for a period of 2 months to ensure compliance with community policies and procedures.</p>	<p>11/5/25</p>