Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33581N	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE – WELDON SPRING	400 SIEDENTOP ROAD WELDON SPRING, MO 63304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4797	19 CSR 30-86.047(46) Safe & Effective Medication System The administrator shall develop and implement a safe and effective system of medication control and use, which assures that all residents ' medications are administered by personnel at least eighteen (18) years of age, in accordance with physicians ' instructions using acceptable nursing techniques. The facility shall employ a licensed nurse eight (8) hours per week for every thirty (30) residents to monitor each resident ' s condition and medication. Administration of medication shall mean delivering to a resident his or her prescription medication either in the original pharmacy container, or for internal medication, removing an individual dose from the pharmacy container and placing it in a small cup container or liquid medium for the resident to remove from the container and self-administer. External prescription medication may be applied by facility personnel if the resident is unable to do so and the resident ' s physician so authorizes. All individuals who administer medication shall be trained in medication administration and, if not a physician or a licensed nurse, shall be a certified medication technician or level I medication aide. I/II This regulation is not met as evidenced by: Class II Based on interview and record review, the facility failed to ensure a safe and effective system of medication administration for one resident (Resident #3), in a review of eight sampled residents. Upon admission to the facility, Resident #3 self-administered his/her medications. On 5/16/25 the facility took over medication administration for the resident. The	A4797		

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A4797	Continued From page 1 facility failed to ensure all of the resident's medications were added to the medication administration record (MAR) by the facility pharmacy on 5/16/25and again on 6/4/25 when the resident had prednisone (steroid) prescribed in tapering doses. The facility did not verify with the physician the medications in November 2024 were the same medications the resident was taking in May 2025. The resident's Plavix (blood thinner) was discontinued by his/her cardiologist on 3/13/25 but was on the medication list provided to the facility in November 2024. The facility kept Plavix on the resident's MAR from 5/16/25 to 5/29/25. Staff omitted ordered Lasix (a diuretic) on the resident's MAR from May 2025 until the end of August 2025 when family noticed the resident had swelling in his/her lower legs and asked about the resident's medications. The facility also failed to verify with the physician the potassium dosage for the resident and failed document staff administration of Tylenol (pain reliever) 650 milligrams every six hours as needed as being administered by the facility staff since 5/16/25. The facility failed to ensure the resident's Advair Diskus, Mucinex, and prednisone were available for administration on multiple days. The facility census was 52. Review of the facility's policy, Medication Management, Orders, Refills and Delivery, dated 5/1/25, showed the following: -As part of the Medication Management Program, the Health and Wellness Director (HWD) will oversee medication and treatment orders, refills, and delivery to the Community in accordance with company policy and procedure and applicable law; -Provider orders will be written, signed, and dated by the provider, and documented in the	A4797		

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A4797	Continued From page 2	A4797		

resident health record. Provider orders should include quantity and refill amounts and indications for use;
-The HWD or licensed nurse designee will process new or changes in medication and treatment orders within 24 hours on the next business day, unless otherwise required by applicable law, to include faxing the order to the pharmacy for processing, as warranted, and documenting the order in the applicable progress note type within the resident health record;
-New or changes in medication and treatment orders will be implemented with the next cycle fill unless related to an acute change in resident condition or otherwise indicated on the order;
-Orders may be documented on the Provider Communication form or similar, provider-supplied form. However, in the case of the latter, the pharmacy will process the order as written: If the provider does not specify quantity and refill amounts on the order, the pharmacy will process the medication/treatment for 30 days with zero refills.

Review of the facility's policy, Medication Administration, dated 11/22/24, showed the following:
-A medication passer was a team member that is licensed, certified, and delegated to administer medications within the scope of applicable law and facility policies and procedures;
-Team members who are appropriately licensed or who, where allowable by law, have been trained, evaluated for competency, and delegated/authorized by a licensed nurse will administer medication to residents receiving medication and treatment management services in accordance with provider orders, applicable law, and facility policy and procedure;

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A4797	Continued From page 3 -For each administration of medication, medication passers will follow the seven rights: right resident, right medication, right dose, right route, right time and day, right reason, and right documentation; -With the resident's electronic medication administration record (eMAR) open, compare the medication listed in the eMAR with the medication label to confirm right one through five and, for as needed (PRN) medication, right six; -After administering medication, the medication passer will document medication administration in the resident's eMAR in accordance with the Medication Documentation policy and procedure; -An undetected or unreported medication incident can expose the resident to harm. Undetected and/or unreported incidents may be worse for the individual than one that is detected and reported; -The medication passer will report to the nurse on duty any changes in the resident's condition or normal functioning observed during medication administration. 1. Review of Resident #3's medication list, provided to the facility by the resident's physician, dated 11/30/24, showed the following: -Norvasc (for high blood pressure) 5 milligrams (mg), one tablet one time a day; -Potassium chloride (supplement often prescribed when a diuretic medication is taken) extended release (ER) 20 milliequivalents (mEq), one tablet every day; -Eliquis (blood thinner) 5 mg, one tablet two times a day; -Finasteride (used to treat enlarged prostates) 5 mg, one tablet one time a day; -Lipitor (used to treat high cholesterol) 80 mg, one tablet one time a day; -Potassium chloride ER 20 mEq, two tablets one	A4797		

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A4797	Continued From page 4 time a day (a second order for potassium chloride 20 mEq); -Advair Diskus (an inhaler used to open the airway) 250 micrograms (mcg) - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day; -Tamsulosin (used to treat enlarged prostates) 0.4 mg, one capsule one time a day; -Lasix (a diuretic) 40 mg.; -Plavix (blood thinner) 75 mg, one tablet one time a day; -Albuterol sulfate (an inhaler used to open the airway to make breathing easier) HFA 90 mcg, inhale two puffs every four to six hours as needed for cough. Review of the facility's Provider Move-In Orders sheet, dated 11/30/25, showed the following: -Medication and Treatment orders: at the resident's election, the resident may self-administer medications and manage the ordering of medications and obtaining necessary supplies; -The move in sheet was signed by the resident's physician. Review of the resident's Individual Service Plan (ISP), 4/24/25, showed the resident received medication management services (this should show the resident did not receive medication management services) and the resident would notify the facility if there was a change in desire for medication and medication treatment/management. Review of the resident's medical record showed the following: -No documentation staff attempted to clarify the Lasix order with the physician to see how often it	A4797		

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A4797	Continued From page 5	A4797		

should be administered and staff did not add Lasix 40 mg to the resident's physician order sheet or medication administration record;
-No documentation staff attempted to clarify the potassium chloride ER order. There were two different orders for potassium chloride, one order showed potassium chloride ER 20 mEq, one tablet every day and one order showed potassium chloride ER 20 mEq, two tablets one time a day. The facility did not clarify with the physician which potassium order to use and the pharmacy entered the potassium chloride 20 mEq, one tablet every day to the resident's physician order sheet and medication administration record and that is what the resident received.

Review of the resident's undated face sheet showed the resident had the following diagnoses:
-Heart failure;
-Atherosclerotic heart disease of native coronary artery (the buildup of plaque in the heart's own arteries, leading to narrowed vessels and reduced blood flow and oxygen to the heart muscle);
-Essential hypertension (high blood pressure without an identifiable underlying condition);
-Long standing persistent atrial fibrillation (an irregular and very often rapid heart rhythm that can lead to blood clots);
-Diabetes (high blood sugar).

Review of the resident's undated physician order sheet (POS) showed the following orders:
-Tylenol (pain reliever) 325 milligrams (mg), two tablets every six hours as needed for pain. Order start date was 5/1/25;
-Amlodipine (used to treat high blood pressure) 5 mg, one tablet by mouth one time a day. Order

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A4797	Continued From page 6 start date was 5/16/25; -Potassium chloride micro tablet 20 mEq, one tablet one time a day. Order start date 5/16/25; -Eliquis 5 mg, one tablet two times a day. Order start date 5/16/25; -Finasteride 5 mg, one tablet one time a day. Order start date 5/16/25; -Lipitor 80 mg, one tablet one time a day. Order start date 5/16/25; -Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day. Order start date 5/16/25; -Tamsulosin 0.4 mg, one capsule one time a day. Order start date 5/16/25; -Aspirin 81 mg, one tablet one time a day. Order start date 5/21/25; -Donepezil 5 mg, one tablet one time a day. Order start date 8/2/25; -Vitamin B-12 500 mcg, one tablet one time a day. Order start date 8/14/25; -Vitamin D3 5,000 units, one tablet one time a day. Order start date 8/14/25; -Albuterol sulfate HFA 90 mcg, inhale two puffs every four to six hours. Order start date 5/16/25 and order end date 6/4/25; -Plavix 75 mg, one table by mouth one time a day. Order start date 5/16/25 and order end date 5/30/25. -(There was no order included for Lasix). Review of the resident's MAR, dated May 2025, showed the following: -Staff did not add Tylenol 325 mg, take two tablets every six hours as needed for fever and body aches to be administered by staff and not by the resident. This medication was listed as self-administer for the entire month of May 2025; -Staff did not add the Lasix 40 mg to the resident's May 2025 MAR as listed on the	A4797		

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A4797	Continued From page 7 resident's medication list dated 11/30/24. Review of the resident's MAR, dated 5/16/25 and 5/17/25, showed the following: -No documentation staff administered amlodipine 5 mg, one tablet by mouth one time a day; the administration boxes were blank; -No documentation staff administered Lipitor 80 mg, one tablet by mouth one time a day; the administration boxes were blank; -No documentation staff administered Plavix 75 mg, one tablet by mouth one time a day; the administration boxes were blank. -No documentation staff administered Eliquis 5 mg, one tablet by mouth two times a day at 8:00 P.M. on 8/16/25 and at 8:00 A.M. on 8/17/25; the administration boxes were blank; -No documentation staff administered finasteride 5 mg, one tablet by mouth one time a day; the administration boxes were blank; -No documentation staff administered Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day on 5/16/25 at 8:00 A.M. and 8:00 P.M. and 5/17/25 at 8:00 A.M.; the administration boxes were blank -No documentation staff administered potassium chloride micro tablet 20 mEq, one tablet one time a day; the administration boxes were blank; -No documentation staff administered tamsulosin 0.4 mg, one capsule one time a day; the administration boxes were blank. Review of the resident's MAR, dated 5/19/25, showed Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day showed staff documented the medication was not available at 8:00 P.M.	A4797		

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A4797	Continued From page 8 Review of the resident's MAR, dated 5/20/25, showed Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day showed staff documented the medication was not available at 8:00 A.M. and at 8:00 P.M. and other/see progress note. There was no documentation in the resident's medical record staff notified the physician the resident's Advair Diskus was not available for administration. Review of the resident's MAR, dated 5/21/25, showed Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day showed staff documented the medication was not available at 8:00 A.M. and 8:00 P.M. Review of the resident's MAR, dated 5/22/25, showed Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day showed staff documented the medication was not available at 8:00 A.M. and at 8:00 P.M. it was documented by staff as other/see progress note. Review of the resident's MAR, dated 5/23/25, showed Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day showed staff documented the medication was administered at 8:00 A.M. and the medication was not available at 8:00 P.M. Review of the resident's MAR, dated 5/24/25, showed Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day showed staff documented the medication was not available at 8:00 A.M. and	A4797		

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A4797	Continued From page 9 was administered at 8:00 P.M. Review of the resident's MAR, dated 5/25/25, showed Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day showed staff documented the medication was not available at 8:00 A.M. and 8:00 P.M. Review of the resident's MAR, dated 5/26/25, showed Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day showed staff documented the medication was administered at 8:00 A.M. and the medication was not available at 8:00 P.M. Review of the resident's MAR, dated 5/27/25, showed Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day showed staff documented the medication was not available at 8:00 A.M. and at 8:00 P.M. it was documented by staff as other/see progress note. Review of the resident's MAR, dated 5/28/25, showed Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day showed staff documented the medication was not available at 8:00 A.M. and 8:00 P.M. Review of the resident's MAR, dated 5/29/25, showed Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day showed staff documented the medication was not available at 8:00 A.M. and 8:00 P.M. Review of the resident's progress notes, dated	A4797		

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A4797	Continued From page 10 5/29/25, showed the following: -Staff clarified with the cardiologist's office the resident's orders for Plavix 75 mg, Eliquis 5 mg, and aspirin 81 mg; -The cardiologist's office said Plavix 75 mg was discontinued as of 3/13/25; -The cardiologist's office said the resident should continue taking Eliquis 5 mg and aspirin 81 mg. Review of the resident's MAR, dated 5/30/25, showed staff administered Advair Diskus 250 mcg - 50 mcg/dose powder for inhalation, one puff by inhalation two times a day at 8:00 A.M. and staff documented the medication was not available for administration at 8:00 P.M. Review of the resident's POS, dated 5/30/25, showed Plavix 75 mg was completed (it should not have started on 5/16/25 when the facility took over the resident's medication management as it was discontinued on 3/13/25). There was no documentation in the resident's medical record staff notified the resident's physician the resident's Advair Diskus was not available for multiple administrations in May 2025. Review of a facility Provider Communication Form, dated 6/4/25, signed by the resident's facility's physician showed the following: -Prednisone 40 mg, one time a day for three days, then; -Prednisone 30 mg, one time a day for three days, then; -Prednisone 20 mg, one time a day for three days, then; -Prednisone 10 mg, one time a day for three days and stop;	A4797		

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A4797	Continued From page 11 -Mucinex (an expectorant medication that works by thinning and loosening mucus in the chest and throat, which makes it easier to cough up) 600 mg, two times a day for 10 days; -Change albuterol inhaler to two puffs four times a day scheduled for one week. Then change to every six hours as needed. Review of the resident's MAR, dated June 2025, showed the following: -Staff did not add Tylenol 325 mg, take two tablets every six hours as needed for fever and body aches to be administered by staff and not the resident. This medication was listed as self-administer for the entire month; -No documentation on the MAR staff added Lasix 40 mg; -No documentation on the MAR staff added prednisone 30 mg, one time a day for three days (should have been administered 6/7/25 - 6/9/25). Review of the resident's physician order sheet showed the following: -Albuterol sulfate HFA 90 mcg, inhale two puffs every four hours as needed. Order start date 6/4/25 and order end date 6/7/25 (this order should have been scheduled not as needed); -Prednisone 10 mg, four tablets one time a day for three days. Order start date 6/4/25 and order completed on 6/7/25; -Prednisone 20 mg, one tablet one time a day for three days. Order start date 6/10/25 and order completed on 6/13/25; -Prednisone 10 mg, one table one time a day for three days. Order start date 6/13/25 and order completed on 6/16/25; -No documentation staff entered an order for prednisone 30 mg, one time a day for three days. (this should have been administered 6/8/25 to	A4797		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE – WELDON SPRING	400 SIEDENTOP ROAD WELDON SPRING, MO 63304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4797	Continued From page 12 6/10/25). Review of the resident's MAR, dated 6/6/25 and 6/7/25 showed the resident received prednisone 40 mg one time a day for two days and should have gotten it for three days. Review of the resident's MAR, dated 6/8/25, showed staff did not add prednisone 30 mg one time a day to be administered 6/8/25 through 6/10/25. Review of the resident's MAR, dated 6/8/25, showed the following: -Staff documented Mucinex 600 mg tablet was not available for administration at 8:00 P.M.; -Staff did not add prednisone 30 mg one time a day for administration. Review of the resident's MAR, dated 6/9/25, showed the following: -Staff documented Mucinex 600 mg tablet was not available for administration at 8:00 P.M.; -Staff did not add prednisone 30 mg one time a day for administration. Review of the resident's MAR, dated 6/11/25, showed staff documented Mucinex 600 mg tablet was not available for administration at 8:00 A.M. and 8:00 P.M. Review of the resident's MAR, dated 6/13/25, showed the following: -Staff documented Mucinex 600 mg tablet was not available for administration at 8:00 P.M.; -Staff documented prednisone 10 mg was not available for administration. There was no documentation in the resident's	A4797		

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A4797	Continued From page 13 medical record staff notified the physician the resident's prednisone and Mucinex were not available in June. Review of the resident's MAR, dated July 2025, showed the following: -Staff did not add Tylenol 325 mg, take two tablets every six hours as needed for fever and body aches to be administered by staff and not the resident. This medication was listed as self-administer for the entire month; -No documentation of ordered Lasix. Review of the resident's undated POS showed an order for Lasix 20 mg, one tablet one time a day. Order start date 8/27/25. Review of the resident's MAR, dated August 2025, showed the following: -Staff did not add Tylenol 325 mg, take two tablets every six hours as needed for fever and body aches to be administered by staff and not the resident. This medication was listed as self-administer for the entire month. -Staff did not add Lasix 20 mg to be administered until 8/27/25. Review of the resident's MAR, dated September 2025, showed staff did not add Tylenol 325 mg, take two tablets every six hours as needed for fever and body aches to be administered by staff and not the resident. This medication was listed as self-administer for the entire month. During an interview on 9/2/25 at 1:51 P.M. the resident's family member said the following: -The family member took the resident to their home for a party on 8/23/25 and noticed his/her lower legs were swollen;	A4797		

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A4797	Continued From page 14 -The family member asked the facility for a copy of the resident's medication list. After he/she reviewed the list he/she realized the resident had not taken Lasix since the facility took over the management of the resident's medications in the middle of May 2025. -The family member told staff the resident should be taking Lasix; -The family was upset the resident had not been given his/her Lasix. During an interview on 9/2/25 at 2:43 P.M. the Care Team Manager, said the following: -The resident was admitted to the facility on 11/30/24; -The resident self-administered his medication until 5/18/25; -The family set up the resident's medications in a daily pill container each week; -The Care Team Manager noticed the resident skipped taking his/her medication off and on when she looked at the pill container and pill remained on days he/she should have taken them; -The facility talked to the family about taking over medication management for the resident and that began on 5/18/25. During an interview on 9/2/25 at 3:50 P.M. and 9/11/25 at 4:36 P.M. the Health and Wellness Director said the following: -The resident was admitted to the facility on 12/27/24; -After the resident was admitted to the facilty he/she was under the care of the facility physician. The resident had not gotten any new orders from the facilty physician since he/she was admitted. -The facility began administering medications to	A4797		

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A4797	Continued From page 15 the resident in May; -She did not contact the resident's physician to verify that orders from 11/30/24 were all medications the resident was currently taking; -She did not change the resident's Tylenol from self-administer to facility administering the medication. She should have done that in May when the facility began administering the resident's medications; -Staff did not notify the Health and Wellness Director they were not able to chart when they administered Tylenol to the resident because it was on the MAR as self-administer. She knew the resident had gotten Tylenol on occasion since the facility began administering his/her medications and it should have been charted on the MAR; -Towards the end of August, the resident's family said the resident no longer took Plavix, he/she only took Eliquis and aspirin. She told the family the facility would need a written order from the physician to clarify the order and family brought in the order; -When new orders come in from a physician or a new resident arrives the orders are sent to the pharmacy. The pharmacy enters the orders on the physician order sheet (POS) and the MAR; -It was her responsibility to verify the orders after the pharmacy entered them and sent them back to the facility. She does an audit every two weeks when the pharmacy begins a new cycle of medications; -She did not notice there were two potassium chloride orders on the original admission orders and did not verify them with the physician. She just verified the order the pharmacy put on the POS and the MAR; -She said since the Lasix order was not a complete order with instructions on how often to	A4797		

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A4797	Continued From page 16 take it, the pharmacy would not enter it; -She did not see the Lasix order and did not verify it with the physician; -Staff marked medications as not available because they did not know where to find the medication in the medication cart. The Health and Wellness Director felt is was an education issue and not that the medications were not available. She did in-service staff in May and felt the issue was resolved; -She expected staff to document a reason a medication was not administered and staff should let her know if a medication was not available so the physician could be notified. MO258187	A4797		

PLAN OF CORRECTION

Provider/Supplier Name:	New Perspective Weldon Spring
Street Address, City, Zip:	400 Siedentop Rd Weldon Spring MO 63304

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4797	HWD notified the pharmacy to conduct an audit of resident #3 medications as well as contacting his physician to get clarifications of his orders. An in-service was conducted with all L1MA's by the Care Team Manager who went over the policies involving Medication Management, Medication Non-Availability & Medication Refusal. Regional Director of Health and Wellness met with HWD and reeducate on all Medication Management Policy and Procedures including Meds not available, Meds refused HWD will monitor medication dashboard in PCC Daily for 30 days for compliance of med administration. She will review POS of each resident every 2 weeks with cycle change over of medication. RDHW will monitor randomly for 6 months and as needed the medication dashboard in PCC and provide any needed follow up with HWD. All residents have the potential to be affected.	10/1/2025

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.