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
	00546C	A. BUILDING: _____ B. WING _____	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG BEND RETREAT	620 NORTH EMMERSON SLATER, MO 65349

(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
A4356	19 CSR 30-86.043(49) 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 or distributed by personnel at least eighteen (18) years of age, in accordance with physicians ' instructions using acceptable nursing techniques. Until January 1, 1991, those facilities administering medications shall utilize personnel trained in medication administration (a licensed nurse, certified medication technician or level I medication aide) and shall employ a licensed nurse eight (8) hours per week for every thirty (30) residents to monitor each resident ' s condition. Distribution shall mean delivering to a resident his/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 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. After December 31, 1990, all persons who administer or distribute 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 observation, interview and record review, the facility failed to implement a safe and effective system of medication control for four residents (Resident #1, #2, #3 and #4) in a review of four sampled residents. Staff	A4356		

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A4356	Continued From page 1 pre-prepared four residents' medications, approximately one hour prior to the administration time by placing each resident's medications in a small cup on a tray with a card for each cup labeled with the residents' names. There was no information identifying what medications were in each of the cups. Staff left the tray of pre-prepared medications in a locked room where multiple other staff had access to the medications. During the medication administration observation, staff left the tray of medications in an unlocked area and out of sight while administering the medications to residents. The facility census was five. Review of the facility policy, Medication Policy and Procedure, dated 09/15/2000, showed the following: -It shall be the policy of the facility to insure provision of a safe and effective system for the control and use of medication; -All medication shall be secured by keeping the med room door locked except when the charge nurse is in the process of preparation in such room; -Medications shall be inaccessible to residents and unauthorized persons while being transported and administered; -Time and dose of medication administered to the resident shall be properly recorded at the time of administration in each resident's medication record by the person who administered the medication. 1. 1. Review of the Level I Medication Aide (LIMA) Instructor manual dated February 1998 showed the following: -All medications should be clearly identified, never leave a tray or unlocked medication cart	A4356		

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A4356	Continued From page 2 out of your sight; -Do not punch out medications from the bubble card until you see resident. 2. Observation on 09/04/25 at 12:05 P.M. showed the following: -The Assistant Director Of Nursing (ADON) entered the locked nursing office where the medication cart sat with the Medication Administration Record (MAR) on top of it; -A rolling cart sat across from the med cart and held a medication tray which held 18 medication cups, each filled with different colors and sizes of medications (some whole in applesauce and some crushed); -Each medication cup had a small card behind it; -The resident's names and room numbers included Resident #1, #2, #3, #4. 3. During an interview on 09/04/25 at 12:05 P.M., the ADON said the facility was allowed to set their medications up ahead of time as it was easier and saved time. She added she had set the medications up, on the medication tray, around 10:30 or 11:00 A.M. for both the Intermediate Care Facility (ICF) and Residential Care Facility (RCF) noon medication pass. 4. Observation on 09/04/25 at 12:08 P.M. showed the following: -The ADON picked up Resident #1's medication cup from the medication tray, sat it on the medication cart and pulled the resident's bubble pack from the medication cart. The ADON and the inspector reviewed the pill pack and the pills in the medication cup and compared them to the scheduled pills for the noon pass; -The ADON picked up the medication cup, exited the room and without closing or locking the door,	A4356		

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A4356	Continued From page 3 entered the dining room, located the resident and administered the medications to the resident; -The ADON could not visualize the medication cart or the tray of medications on the rolling cart, from the dining room; -Residents sat within four feet of the opened, unlocked nursing office/medication room. 5. During an interview on 09/10/25 at 1:15 P.M., the ADON, LPN (Licensed Practical Nurse)said the following: -She had worked at the facility for three years and she was told they could set up all of their medications one hour before the pass, placing them in the cups on the medication tray; -She was trained on the practice of medication administration when she first worked as a Level One Medication Aide (LIMA) and then received her Certified Medication Technician (CMT) and eventually in nursing school; -She prepared the medications in the nursing office/medication room where the medication cart sat and the medication tray remained there (in the locked room) until the time she would begin her pass; -The medication cart would not fit between all of the tables in the dining room, so they prepared them in the nursing office/extended medication room with the medication tray on the rolling cart and the MAR beside it; -She had set Resident #1's medications up at 11:00 A.M. prior to the passing of the medications at 12:08 P.M.; -Normally she would push the rolling cart with the medication tray through the dining room, however with the inspector present and needing to see the MAR, the pill packets, etc., it was confusing; (she normally did not check the medications against the pill packs a second time,	A4356		

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A4356	Continued From page 4 she just did that for the inspector); -The medication cards did not include the medication names and dosage; -Medications should be monitored or locked securely at all times; -She could not see the prepared medications when in the dining room administering medications when her back was to the room; -She signed the medications out as administered at the same time she set them up (one hour before); -Medications set up ahead of time and left uncovered could become contaminated by dust, germs, etc.; -Persons having access to the nursing office/med room were the Administrator, herself and the Director of Nursing (DON). 6. During an interview on 09/09/25 at 1:50 P.M., the DON said the following: -Staff have one hour before medication pass was due, so they set up the pills within the hour before; -They set them up at the medication cart in the nursing office/med room; -The small medication room was not large enough for the medication cart and to set up the medications; -The medication cards had the resident's name, room number and the time the medication was due (some may include parameters); -She did not know if the medication name and dosages should be on the medication cards; -She and the charge nurse had access to the nursing office/med room in the daytime, but the administrator and maintenance person also had access; -The nursing office door should not be left open and unlocked, as someone could enter and get	A4356		

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A4356	Continued From page 5 the medications; -The medications should be locked up if not within staff's sight; -Medications should be signed off after administration; -Medications set up ahead of time and left uncovered could become contaminated. 7. During an interview on 09/09/25 at 1:55 P.M., the Administrator said she would expect the following: -Medications to be within eyesight of the medication nurse or the medication to be behind a locked door; -She would not want medications set up ahead of time to be uncovered due to contamination.	A4356		

PLAN OF CORRECTION

Provider/Supplier Name:	Big Bend Retreat
Street Address, City, Zip:	620 N. Emmerson Slater, MO 65349

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
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A4356	In-service education will be provided to all LPN's on proper medication administration. LPN's are the only staff in the facility who do med pass at this time. Education will include not to pre-set or pre-pour medications and line of sight policy. D.O.N. will monitor for continued compliance by observing a random med pass weekly for a year. All residents could be affected by this deficient practice.	10/08/2025

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.