STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265447	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McDonald County Living Center	1000 Patterson Street Anderson, MO 64831

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to provide pharmaceutical services that ensured administration of all drugs to meet the needs of each resident when staff failed to have multiple medications available for administration for one resident (Resident #3) and failed to follow-up with the physician and pharmacy regarding the missed doses. The facility census was 56. Review of the facility's policy titled, Medication, Administration Guidelines, undated, showed the following: -It is the purpose of the facility that residents receive their medications on a timely basis and in accordance with established policies; -The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's order, giving the individual dose to the proper resident, and promptly recording the information;-The same person preparing the doses for administration must administer the medications;-The person administering the drugs must chart the medications immediately following the administration. The date, time administered, dosage, etc. must be entered in the medical record and signed by the person entering the data. 1. Review of Resident #3's face sheet (a document that gives a resident's information at a quick glance) showed the following:-readmission date of 06/10/25; -Diagnoses included surgery genitourinary system - resection of a bladder tumor, urinary tract infection with bacteremia hematuria (blood present in the urine), urine retention, and benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland that can cause urinary problems), and depression. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/14/25, showed the following: -Cognition intact;-Required supervision for transfers. Review of the resident's care plan, updated 06/16/25, showed the following: -The resident required an indwelling urinary catheter (a thin, flexible tube used to drain and collect urine from the bladder) due to bladder tumor and prostate enlargement;-The resident was at risk of adverse consequences due to receiving antidepressant medication for treatment of depression. Review of the resident's June 2025 Physician Order Sheet (POS) showed the following:-An order, dated 05/16/25, for duloxetine capsule, delayed release (used to treat depression), 60 milligram (mg) capsule once per day;-An order, dated 05/16/25, for (used to treat benign prostatic hyperplasia), one 5 mg tablet once a day; -An order, dated 05/16/25, for mirabegron (used for overactive bladder), 50 mg tablet extended release 24-hour, one tablet daily; -An order, dated 06/10/25, for saccharomyces boulardii (probiotic), one 250 mg capsule twice a day; -An order, dated 05/16/25, for solifenacin (used for overactive bladder), one 10 mg tablet once a day. Review of the resident's June 2025 Medication Administration Record (MAR) showed the following:-An order, dated 05/16/25, for duloxetine capsule, delayed release, 60 mg capsule once per day. Staff did not administer the medication on 06/11/25, 06/12/25, and 06/13/25 due to drug item unavailable;-An order, dated 05/16/25, for Finasteride, administer one 5 mg tablet once a day. Staff did not administer the medication on 06/11/25, 06/12/25, 06/13/25, and 06/15/25 due to drug item unavailable;-An (continued on next page)

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.

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order, dated 05/16/25, for mirabegron, 50 mg tablet extended release 24 hour, one tablet daily. Staff did not administer the medication on 06/11/25, 06/12/25, 06/13/25, and 06/14/25 due to drug item unavailable;-An order, dated 06/10/25, for saccharomyces boulardii , one 250 mg capsule twice a day. Staff did not administer the medication on 06/10/25, 06/11/25, 06/12/25, 06/13/25, 06/14/25, and morning of 06/15/25 due to drug/item unavailable awaiting arrival from the pharmacy.-An order, dated 05/16/25, for solifenacin, one 10 mg tablet once a day. Staff did not administer the medication on 06/11/25, 06/12/25, 06/13/25, and 06/14/25 due to drug item unavailable. Review of the resident's nurses' notes, dated 06/11/25 through 06/14/15, showed staff did not documentation contacting the pharmacy or the physician regarding medications not being administered as ordered.During an interview on 07/24/25, at 3:08 P.M., Certified Medication Tech (CMT) B said the following:-If a resident does not have medication in the cart, then staff should check the stat safe, administer the medication, and document that he/she got it from stat safe;-There is a button on the electronic medication record (EMAR) to reorder medication and that should be clicked if they are running out or it is not available;-He/she was not sure why the resident did not have some of his medication initially upon readmit . Staff should have reached out to the pharmacy and the physician;-Residents should get medication as ordered. During an interview on 07/24/25, at 1: 53 P.M., Licensed Practical Nurse (LPN) A said the following:-He/she was not sure why the resident's medication was not administered as ordered. Resident medications should be administered per the physician's order;-If a medication is not available, staff should contact the pharmacy to see why it is not there and then check the stat safe to see if they can get medication from there. If they are unable to get it from the stat safe, they should inform the physician;-It would not be appropriate for medication to not be available and not do some sort of follow up.During an interview on 07/30/25, at 12:19 P.M., LPN C said the following:-Medication should be administered per physicians' order;-When a resident is admitted , the orders are generally sent to the pharmacy. If the medication is not at the facility, they should check the stat safe and if it is not there, they should call the pharmacy and physician for next steps;-A resident should not go multiple days without ordered medication.During an interview on 07/30/25, at 12:45 P.M., LPN D said the following:-He/she makes sure to administer medication as ordered and if that is not possible due to not being available then they should contact the physician;-If the facility does not have the medication, they should check the stat safe and call the pharmacy;-If they cannot get it quickly they should call the physician.During interviews on 07/24/25, at 2:49 P.M., and 07/30/25, at 1:30 P.M., the Director of Nursing, (DON) said the following:-The pharmacy said they only got orders for the resident's new medications from hospital. The orders for the other medication were not discontinued but they were not reordered. The resident should have been receiving the medications as ordered. He/she is not sure why the medications were not reordered from the pharmacy;-He/she would have expected staff to contact the pharmacy sooner, the first date that they were not available;-He/she did not know if the physician was called but he/she would have expected staff to if they did not have the medication available; -Medications should be administered per the physicians order and the facility policy;-The resident's medications were not discontinued in May when he/she discharged from the facility and then when he readmitted they did not get reordered from the pharmacy. That is why they were not available. During an interview on 07/24/25, at 1:50 P.M., the Administrator said he/she would expect medications to be administered per the physician orders. During an interview on 07/30/25, at 1:36 P.M., the Quality Assurance Nurse said the following:-He/she expected staff to administer medication as ordered. The staff should follow the facility policy;-If medications were not available staff should call the pharmacy and check the stat safe;-Staff should find out why the medications were (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not received by the facility and if there is a delay in getting the medications then they should let the physician know to see if they need to give something else. Complaint #1778398

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure all residents were free from significant medication errors when staff administered one resident's (Resident #2) insulin to another resident (Resident #1) who did not have orders for insulin and no diagnosis of diabetes. The facility census 56. On 06/25/25, during morning medication pass, Licensed Practical Nurse (LPN A) discovered the medication. The LPN notified the Administrator, Director of Nursing (DON), physician, and family of the medication error. The LPN completed monitoring until the resident left for the hospital. The DON completed an investigation and in-service of all staff on 06/25/25. The facility corrected the non-compliance by 06/26/25. Review of the facility policy titled, Medication, Administration Guidelines, undated, showed the following:-The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's order, giving the individual dose to the proper resident, and promptly recording the information;-If there is doubt as to the correct identification of a resident, medication may not be administration to that resident until positive identification has been made. Review of the facility policy titled, Medications, Errors and Drug Reactions, undated, showed the following:-The purpose is to safeguard the resident and provide emergency care as necessary;-Report all medication error and adverse reactions immediately to the attending physician, Director of Nursing (DON) and Administrator;-Document and following the attending physician orders;-Complete resident assessment.1. Review of Resident #2's face sheet a document that gives a resident's information at a quick glance) showed the following:-admission date of 05/04/25;-Diagnoses included type two diabetes mellitus with diabetic peripheral angiopathy without gangrene (a chronic condition where the body either doesn't produce enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels with peripheral artery disease affecting the blood vessels of the limbs). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/25/25, showed the resident was cognitively intact and required substantial assistance. Review of the resident's June 2025 Physician Order Sheet (POS) showed the following:-An order, dated 12/03/25, for Lantus U-100 Insulin (long-acting insulin) solution 100 unit/milliliter (ml), 10 units subcutaneous (under the skin) once a day at 7:00 A.M.;-A current order for Novolog U-100 Insulin (fast acting insulin) solution 10 unit/ml. Administer subcutaneously per following sliding scale;-If blood sugar measured less than 70 milligrams/deciliter (mg/dL), call physician;-If blood sugar measured 70 mg/dL to 130 mg/dL, administer 0 units of insulin;-If blood sugar measured 131 mg/dL to 180 mg/dL, administer 2 units of insulin;-If blood sugar measured 181 mg/dL to 240 mg/dL, administer 4 units of insulin;-If blood sugar measured 241 mg/dL to 300 mg/dL, administer 6 units of insulin;-If blood sugar measured 301 mg/dL to 350 mg/dL, administer 8 units of insulin;-If blood sugar measured 351 mg/dL to 400 mg/dL, administer 10 units of insulin;-If blood sugar measured greater than 400 mg/dL, administer 12 units of insulin and call the physician; -Special instructions to offer snack if meal isn't within 5 to 10 minutes of administration. Review of the resident's blood sugar dated 06/25/25, at 6:40 A.M., showed it measured 141 mg/dl. 2. Review of Resident #1's face sheet (showed the following:-admission date of 02/28/22;-No diagnoses of diabetes. Review of the resident's discharge Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/25/25, showed the resident required substantial assistance for transfers.Review of the resident's June 2025 POS showed no orders for insulin administration. Review of the resident's nurses' notes showed the following:-On 06/25/25, at 6:10 A.M., Licensed Practical Nurse (LPN) A said an aide said the resident was not acting right. Upon entering room, the resident was observed sitting in his/her (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair, eyes open and fixed on the ceiling, drooling, and entire body was shaking. The resident appeared to be having a seizure. The resident would not respond to verbal commands. The resident's pupillary light response was appropriate. The resident vital signs were stable. The resident was not at baseline. Staff notified the physician and received an order to send to the resident to the hospital. Staff notified the resident's next of kin. Emergency Medical Services (EMS) arrived to transport the resident. Staff notified the DON and called a report to the hospital;-On 06/25/25, at 9:57 A.M., LPN A said the resident was having possible seizure activity. The resident was up front to monitor resident's condition. Resident #1 was sitting by another resident and that resident that was diabetic. The LPN administered Resident #2's medication to Resident #1 who was not diabetic. Staff notified the hospital, the DON, the physician, and the resident's family of the medication error. The resident was asymptomatic from the medication error;-On 06/25/25, at 1:11 P.M., staff made a medication error note. The DON said the resident was given two units of Novolog and ten units of Lantus by mistake by previous nurse. The residents blood sugar was checked immediately after this error and was 123 mg/dL. Staff notified the physician, Administrator, and DON of the error. The resident was already being sent out for psych issues. The resident experienced no side e?ects before leaving for hospital. Staff notified hospital of error in report as well by previous nurse;-On 06/25/25, at 1:16 P.M., the DON said the resident was admitted to the hospital for metabolic encephalopathy (a condition where the brain does not function properly due to underlying metabolic disturbances) and a urinary tract infection. Review of the Resident #1's Medication Error Investigation, undated, showed the following:-Insulin was stored in the right spot on the medication cart. Resident #1 had no orders for insulin. Resident #1 was placed up front for further monitoring while waiting for emergency medication services. Resident #1 was placed next to another resident (who was diabetic) per the nurse who administered the insulin to Resident #1. The nurse had drawn up the insulin for the resident sitting next to Resident #1 to administer while waiting or EMS to arrive for Resident #1. The insulin was given to Resident #1 instead of the resident it was for. Resident #1 blood sugar was immediately checked, and it was 123 mg/dL. Resident #1 was given two units of Novolog and 10 units of Lantus. Resident #1 was already going to the hospital for seizure like activity. The hospital, physician, resident's next of kin, Administrator and the DON were all notified of the error. The resident was admitted to the hospital for metabolic encephalopathy and urinary tract infection;-A statement signed by LPN A dated 06/25/25, at around 6:30 A.M., showed he/she made a medication error. He/she administered two units of Novolog and 10 units of Lantus to Resident #1. Resident#1 did not have orders for the medication. Resident #1 was having seizure like activity at approximately 6:00 A.M. An order was obtained to send the resident to the hospital. Ambulance services were called to transport the resident to the hospital. He/she had the resident where he/she could monitor him/her by the medication cart. A resident with diabetes was also near the medication cart. He/she had his/her insulin prepared and ready to administer to the resident with diabetic when Resident #1 began having seizure. He/she mistakenly administered the insulin to Resident #1 instead of the resident that was supposed to receive the insulin. Resident #1's blood glucose was immediately checked with a result of 123 mg/dL. Resident #1 was asymptomatic, and the ambulance arrived immediately afterwards. He/she notified the provider, the hospital, and the DON of the medication error. 3. During an interview on 07/24/25, at 1: 53 P.M., LPN A said the following:-On 06/25/25, he/she made a medication error. Resident #1 was having seizure like activity at 6:00 A.M., his/her eyes were open but fixed. His/her vital signs were fine, but he/she was not responding much. He/she brought him/her to the nurses' station to keep an eye on him/her. He/she called for an ambulance. While waiting for the ambulance he/she gave Resident #1 the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	insulin that was meant for Resident #2. He/she checked Resident #2's blood sugar and then gave the medication to the wrong resident. He/she gave Resident #1 two units of Novolog and 10 units of Lantus. Resident #1 did not have an order for the insulin and is not diabetic.-He/she was not sure how she made the mistake. The residents were sitting next to each other, but he/she was familiar with both residents. He/she realized immediately after giving the Lantus that he/she had given it to the wrong resident;-He/she checked Resident #1's blood sugar and it was okay. He/she called the physician and then called the hospital to let them know in report. He/she also called the next of kin.-He/she then gave the correct medications to Resident #2.-Resident #1 went to the hospital about five minutes later. There was no change in Resident #1. During an interview on 07/24/25, at 3:08 P.M., CMT B said the following:-He/she had been educated about giving medications and how to prevent errors. He/she was supposed to use the five rights to prevent mistakes;-Medications should be administered to resident's as ordered by the physician;-If there is a medication error they are supposed to let the DON and physician know.During an interview on 07/30/25. at 12:19 P.M., LPN C said the following:-He/She was not aware of any medication errors recently, but she was educated about the five rights and making sure they are administering the right medication at the right dose, through the right route to the correct resident. Medication should be administered per physician's order.During an interview on 07/30/25, at 12:45 P.M., LPN D said the following:-He/she ensured that he/she was giving the correct medication to the correct resident by double checking and using the five rights. If she did make a medication error, she would immediately report it to the DON and physician;-He/she makes sure to administer medication as ordered.During an interview on 07/30/25, at 1:30 P.M., the DON said the following:-LPN A made a medication error on 06/25/25 when he/she gave medication for Resident #2 to Resident #1. He/she immediately assessed the resident and called the physician and DON;-An investigation was completed. He/she was unsure of the exact cause of an error but it was hectic due to Resident #1's change of condition status right at shift change. Staff have received education regarding administering medication as ordered following the 5 rights to prevent errors. The staff are to always look at the Medication Administration Record (MAR) and not just the cards in the drawer; -Resident #1 was already being sent to hospital for a change in condition prior to the error;-Resident #1's blood sugars checked and were okay; -He/she would expect staff to ensure it was the correct patient and the correct medication/dose. -Medications should be administered per physician order and follow the facility policies. During an interview on 07/30/25, at 1:36 P.M., the Quality Assurance Nurse said the following:-He/she would expect staff to look at the physician orders and follow the five rights of medication of administration. They should also look at the picture that is in the medical record;-If there is a medication error the staff should notify the physician, contact family, and start an investigation of the error;-He/she expected staff to administer medication as ordered.During an interview on 07/24/25, at 1:50 P.M., the Administrator said the following:-There was a medication error with Resident #1;-LPN A had sat the resident next to Resident #2 and accidently administered insulin to Resident #1. The DON completed an investigation;-The resident's blood sugar was okay when he/she left the facility to go to the hospital;-He/she would expect medications to be administered per the physician orders. Complaint #1778395