

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2025
NAME OF PROVIDER OR SUPPLIER Florissant Valley Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Graham Road Florissant, MO 63031	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37672</p> <p>Based on interview and record review, the facility failed to ensure a resident was administered alprazolam (Xanax, used for anxiety) as ordered. In addition, the facility failed to ensure the physician was notified timely when the medication was not delivered and the resident missed multiple doses. The resident experienced anxiety and tearfulness as a result (Resident #3). The sample was 4. The census was 78.</p> <p>Review of the controlled substance prescriptions policy, dated 8/2014, showed:</p> <p>-Policy:</p> <p>-Before a controlled drug can be dispensed, the pharmacy must be in receipt of a clear, complete and signed written prescription from a person lawfully authorized to prescribe. A chart order is not equivalent to a prescription for controlled drugs. Therefore, the prescriber issuing the chart order must also provide the pharmacist with a valid prescription. The written prescription may be faxed to the pharmacy for long term care residents;</p> <p>-Verbal orders for controlled medications are permitted for class II (CII, a class of drugs with a high potential for abuse) controlled drugs only in emergency situations. Verbal orders for controlled medications received by nursing staff should be noted in the resident's medical record and staff must confirm the prescriber has communicated the order to the pharmacy. Verbal orders received by the pharmacist from the prescriber must also be communicated to the facility before authorized staff may access any controlled substances from the emergency supply. This may be done by the prescriber directly or via telephone order from the pharmacist to the facility;</p> <p>-Procedure:</p> <p>-The prescriber is contacted to verify or clarify a prescription when needed;</p> <p>-New Prescriptions:</p> <p>-If prescriptions are written by the prescriber and sent with the resident upon hospital discharge, the prescriber is encouraged to document on separate paperwork the fact that a prescription has been provided to ensure accountability on the receiving end. When written prescriptions received by the facility:</p> <p>(continued on next page)</p>

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-If the prescription is from a prescriber other than the attending physician, the order is verified with the current attending physician. The nurse communicated that verification to the pharmacy prior to dispensing;</p> <p>-The prescription is faxed or sent electronically to the pharmacy by the prescriber or prescriber agent.</p> <p>Review of Resident #3's discharge hospital summary, dated 3/12/25, showed:</p> <p>-Principle problem: closed fracture of right tibial plateau (break of the larger lower leg bone below the knee into the cartilage) fracture;</p> <p>-Medication: Xanax 1 milligram (mg) tablet. Take one tablet three times a day. Used for anxiety treatment, control panic disorders. Documented as administered three times daily at morning, noon and bedtime in the hospital;</p> <p>-Discharge disposition: long term care facility.</p> <p>Review of the resident's facility medical record, showed:</p> <p>-admitted : 3/12/25;</p> <p>-An order, dated 3/12/25: Alprazolam (Xanax) tablet 1 mg. Give one tablet three time a day for anxiety;</p> <p>-Diagnoses included fracture of the upper end of the right tibia, muscle wasting and anxiety.</p> <p>Review of the emergency kit (E-kit) medication list, showed:</p> <p>-Alprazolam tablet 0.25 mg, available: 61;</p> <p>-Alprazolam tablet 0.5 mg, available: 10.</p> <p>Review of the resident's March 2025 Medication Administration Record (MAR), showed:</p> <p>-An order, dated 3/12/25 at 6:35 P.M.; Alprazolam 1 mg, take one tablet three times a days for anxiety. Scheduled at 6:00 A.M., 2:00 P.M. and 10:00 P.M.;</p> <p>-On 3/12/25 at 10:00 P.M., documented as NA-not administered see nurse note;</p> <p>-An additional note added to the MAR order, dated 3/13/25 10:18 A.M., showed: hold from 3/13/25 to 3/15/24 at 1:32 P.M.;</p> <p>-On 3/13/25 at 6:00 A.M., 2:00 P.M., and 10:00 P.M., showed: H or on hold by physician.</p> <p>Review of the progress notes, showed:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 3/12/25 at 10:14 P.M., and 3/13/25 at 5:27 A.M., a medication administration note: Alprazolam 1 mg. Give one tablet three times a day for anxiety. Waiting for script and pharmacy approval. No documentation noted of physician or pharmacy follow up;</p> <p>-On 3/13/25 at 10:19 A.M., a skilled nurse note: the resident requires cues and has disorganized thinking. Mood is pleasant;</p> <p>-On 3/13/25 at 11:21 A.M., a skill nursing note: patient is anxious and asks questions repeatedly. Informed of inability to obtain Xanax due to need for script. Offered morning meal and the resident refused. He/She ate toast two hours later. No additional documented physician or pharmacy contact regarding Xanax order;</p> <p>Review of the handwritten pharmacy controlled substance accountability form, dated 3/14/25, showed:</p> <p>-Medication: Xanax 1 mg;</p> <p>-Orders: take one tablet three times a day;</p> <p>-Delivered amount: 21;</p> <p>-Administered: 1;</p> <p>-Left available: 20.</p> <p>Review of the physician visit history and physical admission note, dated 3/14/25, showed:</p> <p>-Generalized anxiety disorder:</p> <p>-Assessment and plan: patient to continue with Prozac (used to treat depression), Buspar (used to treat anxiety) and Alprazolam. Patient is not to attempt a gradual dose reduction (GDR) at this particular time as he/she has a significant stressor with his/her knee fracture and being in the facility away from his/her home;</p> <p>-Other orders: Alprazolam 1 mg. Take one tablet three time a day;</p> <p>-History of present illness (HPI): admitted for medical management for right knee pain following right tibial plateau fracture, non-operative management. Medicines were reconciled. He/She is highly anxious and at times intermittently tearful.</p> <p>During an interview on 3/31/25 at 12:40 P.M., the resident's physician said the resident was very anxious on 3/14/25. The resident was admitted from the hospital with orders for Xanax. The resident wanted to return home. The physician was unaware the resident had not received multiple doses of the Xanax. She expected staff to notify her of any medication issues. She did not receive notification of the Xanax medication needing a signed script, and the hospital would have sent the signed script with the resident upon admission. If staff call her, she can call the pharmacy and give an immediate order, and staff can obtain the medication out of the E-kit. The resident received the Xanax three times a day while in the hospital, and that should have continued upon admission to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/31/25 at 12:50 P.M., a pharmacy representative said the resident's Xanax order was received on 3/13/25 at 12:19 P.M., and delivered to the facility on [DATE] at 7:49 A.M. In addition, the facility's E-kit system also carries Xanax 0.25 mg and 0.5 mg tablets. If the physician would have called and approved the Xanax via phone to the pharmacist, the pharmacist would have provided a code for facility staff to access the E-kit. The representative said there was no documented calls from the facility regarding the Xanax and no requests to access the E-kit Xanax.</p> <p>During an interview on 3/31/25 at 1:28 P.M., the Director of Nursing (DON) said the facility does not keep any carbon copies of when medications are delivered from pharmacy. The facility has had issues getting medications timely from the pharmacy as it is located in Kansas. The DON is not aware if the facility used a local pharmacy as a back up provider. The admitting nurse should verify all medications with the resident's physician. If a signed script is needed, the nurse is responsible to notify the physician and obtain the signed script quickly. Usually the hospital will include the signed script in the discharge paperwork. She could not locate the discharge paperwork for the resident. The resident received routine Xanax while in the hospital and the medication was to continue at the facility on the same schedule. The physician can call the pharmacy and give a verbal order to the pharmacist, the pharmacist can provide a code to the facility nurse for the E-kit and the medication can be obtained. Staff should not document in the MAR an H as it will cause the order to not be active and staff will not know to administer the medication. Staff should document other in the medication note, and document a progress note.</p> <p>MO00251135</p>		