STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265112	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Florissant Valley Health & Rehabilitation Center	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)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to adequately treat pain for one resident (Resident #2) who was actively dying. The sample size was three. The census was 72. Review of the facility's pain management policy, dated 11/15/22, showed:-Policy: The Facility will use a systematic approach to pain management; Recognition, evaluation, treatment, and monitoring of pain. Individuals experiencing pain may receive pharmalogical/non-pharmalogical interventions to assist in pain management. The Facility will provide employees education on pain management & opioid (class of drugs used for pain relief) overdose;-Recognition included recognizing when a resident was experiencing pain and identify circumstances when pain can be anticipated; Evaluate the resident for pain on admission and routinely; Manage/Prevent pain consistent with comprehensive evaluation and plan of care, current professional standards of practice and resident's goal/preferences;-Observe for non-verbal indicators of pain;-Nurses will complete a pain evaluation tool, appropriate for the resident's cognitive status to assist with evaluation of a resident's pain;-Based on the evaluation, Nursing in collaboration with the physician/prescriber, other health care professionals, the resident and/or the resident's representative will develop, implement, monitor and revise, as necessary, interventions to prevent/manage a resident's pain;-Opioids will be prescribed and dosed in accordance with current professional standards of practice and manufacturers' guidelines to optimize their effectiveness and minimize their adverse consequences;-Nursing will notify Practitioner if the resident's pain is not controlled by the current treatment regimen;-Nursing will reassess resident's pain management for effectiveness and/or adverse consequences at established intervals;-If re-evaluation findings indicate pain is not adequately controlled, the Pain Management Regimen and Plan of Care will be revised as indicated.-If pain has resolved or there is no longer an indication for pain medication, the Interdisciplinary Team will work to discontinue or taper analgesics (pain killers) (as needed to prevent withdrawal symptoms). Review of Resident #2's care plan, undated, showed:-Problem: At risk of unmanaged chronic pain related to poly-neuropathy (multiple nerves are damaged in lower body). Interventions included: Administer analgesics as ordered by physician; Document pain on 1-10 scale; Monitor response to analgesics and pain alleviation measures;Observe resident during care for signs of pain; Update physician on effectiveness of analgesics and pain medication;-Problem: The resident was receiving hospice care due to unspecified protein malabsorption. Interventions included: Encourage support system of family and friends; Observe the resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Review of the resident's physician order sheet, showed:-An order, dated 12/29/22, for a pain evaluation, every shift for monitoring of resident's pain level;-An order, dated 8/23/23, for morphine sulfate solution (morphine, opioid pain reliever used to treat moderate to severe pain) 20 milligrams (mg) for every five milliliters (ml), give 0.25 ml every four hours as needed for pain;-An order, dated 1/31/24, may admit to hospice care;-An order, dated 8/22/24, for Hydrocodone-acetaminophen 5 - 325 mg (Norco, opioid pain reliver combined with acetaminophen), take one tablet every eight hours for pain. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 3/1/25, showed:-Severe cognitive deficiency;-Disorganized thinking and inattention present;-Impairment present on both sides of the upper and lower body;-On a scheduled pain medication regimen;-Did not receive pain medication as needed;-Received non-medication intervention for pain;-Resident reported not presence of pain during pain assessment interview;-Received hospice care (provides comfort and support by managing pain and other symptoms at end of life);-Diagnoses included heart failure, aphasia (language disorder that affects ability to communicate) dementia and kidney disease. Review of the resident's Medication Administration Record (MAR), dated March 2025, showed:-On 3/12/25, at 6:00 A.M., the facility administered one Norco to the resident;-On 3/12/25, at 6:30 A.M., the resident had a pain level of 0. Review of hospice focus visit, dated 3/12/25, showed:-The visit was an unscheduled symptom evaluation;-A hospice nurse started the visit at 7:55 A.M. and ended visit at 8:45 A.M.;-Interventions performed: Call for a change in condition and ordered morphine;-The resident started moaning when touched for care;-The resident was nonverbal;-Report was given to the facility nurse who administered morphine 0.25 ml;-Norco 5-325 mg was not given;-The facility nurse administered morphine 0.25 ml to the resident for pain;-Report of visit given to facility nurse, Director of Nursing (DON) and the resident's family member. Review of the resident's controlled substance accountability sheet, undated, for Morphine, showed:-On 3/12/25 at 9:30 A.M., the facility administered 0.25

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to maintain accurate medical records as per their policies for one resident of three sampled residents (Resident #2). The facility failed to document assessments for the actively dying resident; failed to accurately document analgesics (pain medication) on narcotic accountability sheets and on the medication administration records; failed to document when morphine sulfate solution (opioid for moderate to severe pain) was delivered and then wasted by facility staff; failed to document when the resident ran out of morphine including notification to hospice and pharmacy; failed to document interactions with hospice staff and failed to document when a new bottle of morphine was delivered by hospice staff from a local pharmacy. The census was 72.Review of the facility's Medication ordering and receiving from pharmacy; Receiving controlled substances policy, dated 12/17, showed:-Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances and medications classified as controlled substances by state law are subject to special ordering, receipt, and recordkeeping requirements by the facility in accordance with federal and state laws and regulations;-The Director of Nursing, in collaboration with the consultant pharmacist, maintains the facility's compliance with federal and state laws and regulations in the handling of controlled substances. Only authorized, licensed nursing and pharmacy personnel have access to controlled substances;-An individual resident's controlled substance record is provided by the pharmacy or the facility for each controlled substance prescribed for a resident. The following information is completed upon dispensing or upon receipt of the controlled substance:I) Name of resident;2) Prescription number;3) Drug name, strength (if designated), and dosage form of medication;4) Directions for use (Controlled Substance Accountability Sheet);5) Date received;6) Quantity received;7) Name of person receiving the medication supply;-A controlled drug record/log is provided by the pharmacy or facility for each controlled drug in the emergency supply;-Only licensed personnel may receive controlled substances from the pharmacy driver. Procedures for receiving controlled substances include:1) A nurse signs for the medications, including the controlled substances, on the pharmacy delivery ticket and inspects the medications;2) A nurse reconciles controlled substance orders and refill requests against what has been received from the pharmacy;3) A nurse notifies the pharmacist if controlled substance orders or doses are missing or incorrect;4) The receiving nurse transfers medications and accompanying inventory sheets to an authorized nurse on the unit (if different than the nurse who received the medication).5) Controlled substance inventory sheets are completed, if necessary, and filed appropriately per state regulation. Review of the facility's controlled substance prescriptions policy, dated 12/17, showed:-The prescriber is contacted for direction when delivery of a medication will be delayed or the medication is not or will not be available;-Each controlled substance prescription is documented in the resident's medical record with the date, time and signature of the person receiving the prescription;-If the medication is not available in the Automated Dispensing Unit (ADU), electronic medication cabinet (EMC) or emergency kit, the nurse contacts the pharmacy to request a STAT delivery of the needed medication. If necessary, the nurse uses the after-hours emergency number(s). Review of the facility's Medication Administration General Guidelines policy, dated 12/17, showed:-Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions;-Medications are prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to prepare and administer medications;-FIVE RIGHTS - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away;-The Medication Administration Record (MAR) is always employed during medication administration. Prior to administration of any medication, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label. If the label and MAR are different and the container has not already been flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. When