STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265185	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Cape Girardeau	365 South Broadview Street Cape Girardeau, MO 63703

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 Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49152 Based on observation, interview, and record review, the facility failed to ensure two residents (Residents #1 and #2) out of five sampled residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices related to pain management. The facility's census was 94. Review of the facility policy titled, Pain Assessment and Management, last revised 09/12/23, showed: - Facility must ensure that pain management is provided to residents who require such services consistent with professional standards of practice, the comprehensive-centered care plan, and the residents' goals and preferences; - Based on assessment, the facility in collaboration with the attending physician/prescriber, other health care professionals, and the resident and/or their representative, develops, implements, monitors, and revises as necessary interventions to prevent or manage each individual resident's pain; - Monitor appropriately for effectiveness and/or adverse consequences; - All residents will be assessed for pain indicators upon admission/readmission, quarterly, and with any change in condition. Review of the facility policy titled, Administration of Medications, last revised 02/13/23, showed: - The facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms; - As needed administrations medications should reflect the initial administration and the additional follow-up performed top determine the effectiveness of the medication administered; - Ensure the medication is working the way it should, medications are reviewed regularly, and ongoing observations are done if required. Review of the facility policy titled, Pharmacy, last revised 01/01/22, showed: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 Note: The nursing home is disputing this citation.	- During normal business hours, facility staff may contact the pharmacy by phone or fax at the phone/fax provided, or by mail or hand delivery; - After normal business hours, facility staff should contact the pharmacy by dialing the telephone number to page the on-call pharmacist; - If orders for medications are received from the pharmacy/prescriber when the pharmacy is closed, the facility should remind the physician the pharmacy is closed and that a delay in medication therapy can be prevented by using a medication in the facility's emergency medication supply; - If a medication cannot be substituted, ask the physician if the medication can be initiated the following morning; - If a medication is considered essential and cannot be substituted or delayed, contact the emergency number provided. Orders should be directly received from a facility nurse or a licensed physician and cannot be faxed, emailed, or provided to the answering service personnel. 1. Review of Resident #1's medical record showed: - admitted [DATE]; - Diagnoses of unspecified fracture of left femur (serious injury that occurs when the thighbone breaks), unspecified fracture of upper end of left humerus (break near the shoulder joint), multiple fractures of ribs left side, Crohn's disease (chronic inflammatory bowel disease), and chronic pain syndrome. Review of the resident's Physician Order Sheet (POS), dated December 2024, showed: - An order for Norco (pain medication) 5/325 milligrams (mg) by mouth every six hours as needed for moderate pain, dated 11/27/24; - An order for acetaminophen (pain medication) 325 mg two tablets by mouth every six hours as needed for pain, dated 11/21/24; - An order for gabapentin (nerve pain medication) 300 mg by mouth two times a day related to chronic pain syndrome, dated 11/21/24; - An order to assess pain level every shift, dated 11/21/24; - An order for Norco 7.5/325 mg by mouth every six hours as needed for pain, dated 12/18/24 at 9:30 A.M.; - An order to assess pain before starting treatment, dated 11/21/24; - An order to cleanse wound with Vasche (wound cleanser) and apply bordered gauze daily, dated 12/01/24. (continued on next page)

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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 Note: The nursing home is disputing this citation.	Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment completed by the facility), dated 11/25/24, showed: - Primary diagnosis of fractures and other multiple trauma; - Cognition intact; - Impairment of upper extremity on one side and impairment of lower extremity on both sides; - Total dependence for dressing, toileting, personal hygiene, bathing; - Dependent with rolling left and right, lying to sitting on side of bed, sit to stand, and chair transfers; - Substantial to max assist with sit to lying; - Used walker and wheelchair for mobility; - On scheduled and as needed pain medication regimen; - Occasionally had pain interference with therapy activities and day-to-day activities; - Had surgical wounds and skin tears; - Application of nonsurgical dressings and wound care; - Occasional pain. Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated December 2024, showed: - Norco 5/325 mg administered on 12/16/24 at 6:02 A.M., for pain level of eight out of 10; - Norco 5/325 mg not administered on 12/17/24 and 12/18/24; - Acetaminophen 325 mg not administered on 12/16, 12/17, or 12/18; - Norco 7.5/325 mg administered on 12/18/24 at 9:47 A.M., for pain level nine out of 10. Review of the resident's Progress Notes showed: - On 12/16/24 at 3:08 P.M., the as needed medication helped the resident's pain. The as needed pain medication available; - On 12/17/24 at 4:53 P.M., staff spoke with the physician's group and was told the pharmacy had to contact them to fill the pain medications. Staff had faxed the pharmacy for refill; - On 12/17/24 at 5:27 P.M., a request for Norco was sent to the pharmacy by fax; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- On 12/18/24 at 8:05 A.M., the pharmacy was called to check on the Norco request. The pharmacy would fill the medication script and send the medication out as soon as possible (STAT) run; - On 12/18/24 at 9:12 A.M., a call was placed to the physician's group due to the resident's pain level being a nine and unable to give the prescribed Norco as the facility was waiting for the pharmacy to fill it. Review of the resident's care plan, last revised 12/07/24, showed: - Resident expressed pain related to surgery to the left hip and broken ribs from a fall at home prior to hospitalization ; - Educate resident and family regarding pain management; - Interventions to evaluate the effectiveness of pain interventions, observe and report complaints of pain or requests for pain treatment; - Observe and report changes in sleep patterns, usual routine, decrease in functional abilities, decrease in range of motion, and withdrawal or resistance to care; - Give pain medications as ordered. During an interview on 12/17/24 at 12:57 P.M., Resident #1 said he/she didn't know when he/she got pain medication last. Resident #1 was is in a lot of pain. He/She said his/her pain was currently a nine and a half on a scale from zero to 10. The pain medication normally helped dull the pain but did not take it away completely. Today was the worst it had been. He/She had a high pain tolerance. Resident #1 said he/she hurt yesterday, and staff did not have anything to give him/her, so he/she just had to deal with it. It was not the first time he/she had to go without pain medication. Resident #1 said they would give him/her acetaminophen, but that was it. He/She should receive pain medication every six hours and now he/she couldn't get it at all. Resident #1 didn't know why he/she couldn't get more pain medications. On 12/16/24 at 10:10 P.M., the nurse told him/her they didn't have the pain medication. Resident #1 said he/she was going to leave the facility, because he/she had pain medication at home, but he/she did not have a way to get to his/her home last night. During an interview on 12/17/24 at 1:55 P.M., Resident #1 said he/she was very angry last night, because he/she believed the staff had been lying to him/her about whether staff had given him/her the pain pill. He/She could not sleep due to the pain, and it had caused him/her to have anxiety due to concerns something was wrong with the way he/she had been healing due to the increased pain levels. It had restricted his/her physical range of motion, mobility and prohibited his/her ability to complete daily tasks, such as using the restroom. During an interview on 12/18/24 at 9:30 A.M., Resident #1 said he/she asked for pain medication several times throughout the night on 12/17/24. Staff said they were still out of the medication. He/She still had not received anything for pain and his/her pain level was a nine or nine and a half out of 10. The facility had been out of medication for over two days now and he/she had not received any pain medication. 2. Review of Resident #2's medical record showed: (continued on next page)

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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 Note: The nursing home is disputing this citation.	- admitted [DATE]: - Diagnoses of acute kidney failure (the kidneys cannot filter waste from the body), hemiplegia and hemiparesis (weakness or paralysis on the left side of the body) following nontraumatic subarachnoid hemorrhage (a brain bleed) affecting the left non-dominant side, acute respiratory failure with hypoxia (body cannot maintain levels of oxygen and carbon dioxide), unspecified hydronephrosis (kidneys swell and stretch due to buildup of urine), chronic obstructive pulmonary disease (COPD - lung disease that block airflow and make it difficult to breathe). Review of the resident's POS, dated December 2024, showed: - An order for acetaminophen 325 mg two tablets by mouth every six hours as needed for pain or fever, dated 11/18/24; - An order for gabapentin 300 mg three times a day by mouth for nerve pain, dated 11/18/24; - An order for Norco 5/325 mg by mouth every six hours as needed for pain, dated 11/18/24; - An order to assess pain level every shift on scale of zero to 10, dated 11/18/24; - An order to assess pain before starting a treatment every shift, dated 11/18/24. Review of the resident's MAR and TAR, dated December 2024, showed: - Norco 5/325 mg administered last on 12/16/24 at 1:00 A.M., for pain level of seven out of 10 with no follow up pain scale showing if medication was effective; - Norco 5/325 mg not administered on 12/17/24 and 12/18/24; - Acetaminophen 325 mg two tablets administered on 12/16/24 at 2:40 P.M., and 8:52 P.M., for pain levels of seven out of 10 both times with no follow up pain scale showing if medication was effective; - Acetaminophen 325 mg two tablets administered on 12/17/24 at 3:06 A.M., for a pain level of five and at 4:55 P.M., for a pain level of eight with no follow up pain scale showing if medication was effective; - Acetaminophen 325 mg two tablets administered on 12/18/24 at 7:53 A.M., for pain level of seven and at 2:28 P.M., for pain level eight with no follow up pain scale showing if medication was effective. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 12/17/24 at 1:55 P.M., Resident #2 said he/she had been out of pain medication for two days and it was starting to make him/her anxious and scared. He/She didn't know when the pain medication would be available next and he/she took acetaminophen instead but it did not do much for the pain. The pain caused him/her to not sleep much at night and his/her appetite was gone. He/She had snacks in the room but did not feel like eating anything because of the pain. Resident #2 had asked for pain medication many times, but did not know when he/she would get any. He/She listened to music or tried to read to distract him/herself from the pain. His/Her pain was an eight out of 10 which was worse than normal. During an interview on 12/17/24 at 3:20 P.M., Resident #2 said he/she asked for pain medication about an hour or two ago. He/She said staff just kept saying they were out of the medication. During an interview on 12/17/24 at 1:55 P.M., Resident #2 said not having pain medication had affected everything. He/She said it had affected his/her whole quality of life. It had affected his/her sleep. He/She did not sleep at all last night and it had affected his/her eating. He/She had snacks in his/her room, but he/she had not been able to eat them because of the pain. Activities had been restricted due to being in too much pain to attend them. The pain had been an eight out of ten on the zero through ten pain scale. Resident #2 had been out of pain medication for two days and was fearful and anxious of when he/she will be able to get the pain medication again. He/She listened to music or read to try and distract his/herself from the pain. Maybe the new physician would change something, but had not seen the new physician yet. During an interview on 12/17/24 at 10:10 A.M., Registered Nurse (RN) A said if staff had an order, they could pull the medications from the Emergency (E) kit and two staff must sign off on it. Staff typically tried to order at least three 30 tablet medication cards for the E kit. The facility was currently having issues running out of Norco 5/325 and the nurse managers must reorder it. It had been out for about two days. Resident #1 used Norco 5/325, so he/she had acetaminophen that was ordered, but someone needed to call and get something stronger for him/her. During an interview on 12/17/24 at 1:11 P.M., the Director of Nursing (DON) said the facility had ran out of scripts and had been using the E kit more than management would have liked. The staff would have to call the physician for a one-time order for a stronger dose when they were out of the lower dose pain medication. Staff had not had any issues getting orders from the physician. A count was conducted of the E kit which showed there were no Norco 5/ 325 mg tablets available. During an interview on 12/17/24 at 2:41 P.M., the DON said she believed RN E sent an order request yesterday for the pain medication for Resident #1. The facility could use a different pharmacy if they needed and could see if the physician would order something different the facility had on hand. During an interview on 12/17/24 at 3:25 P.M., Certified Medication Technician (CMT) B said Resident #2 had been out of the medication for a couple of days. As far as he/she knew, the nurse had been calling the pharmacy or dealing with people on the phone working on getting the medication. A couple weeks ago, a different pain medication ran out. He/She could tell the residents were being affected some without their medications and more residents were asking for their pain medication more frequently. (continued on next page)

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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 Note: The nursing home is disputing this citation.	During an interview on 12/17/24 at 3:30 P.M., Licensed Practical Nurse (LPN) C said he/she was dealing with getting the residents their medications. If he/she was not able to get the ordered medications, then he/she was trying to get substitute medications until the residents normal medications would be available. Some medications the facility had a backup supply in the E kit but the facility was currently out of Norco 5/325 mg tablets. The pharmacy should bring some of the medications tonight or in the morning. This facility just got a new physician and the pharmacy was getting a new internet system so it was making things a little more complicated and delaying things a little. During an interview on 12/17/24 at 4:00 P.M., the Director of Nursing (DON) said the E kit should be there that night. One of the nurses was getting medication straightened out on 100 Hall. During an interview on 12/17/24 at 4:13 P.M., the DON said the residents on 200 Hall should be getting their medication filled tonight. During an interview on 12/18/24 at 8:36 A.M., Resident #2 said he/she was still out of medication so he/she did not receive any pain medication last night. During an interview on 12/18/24 at 8:50 A.M., the DON said the pharmacy did not bring medications last night for the E kit and some residents. She called the pharmacy this morning and they were filling them now and should be delivered today. During an interview on 12/18/24 at 8:57 A.M., Pharmacy Worker I said on 12/17/24 at 12 P.M., the pharmacy received a request for Resident #1 for Norco 5/325 mg as soon as possible. The pharmacy notified the physician yesterday but had not received anything back yet. He/She went and checked the fax machine and the electronic transmission with nothing from the physician yet. The last script filled and sent was on 11/28/24, and 20 Norco 5/325 tablets were sent at that time. For Resident #2, the pharmacy filled the script on 12/16/24 at 4:30 P.M., and delivered it on 12/17/24. If the facility was out of medications and needed them STAT, then the pharmacy would have filled the medications and sent them to the facility as soon as possible. The pharmacy did not know the facility wanted the medications STAT. Observation on 12/18/24 at 9:22 A.M., of Resident #2's medications showed: - Zero Norco 5/325 mg medication. Observation on 12/18/24 at 9:26 A.M., of the E Kit showed: - Zero Norco 5/325 mg medication. During an interview on 12/18/24 at 3:32 P.M., RN E said the previous physician left 11/17/24, and the new physician started to visit to the facility last week. He/She didn't know exactly which residents the new physician saw, but he/she told the new physician the people he/she knew had problems. He/She was pretty sure the new physician saw Resident #1, because he/she had told the new physician about Resident #1 needing pain medications. The facility ran out of the pain medications over the weekend. They got the E kit filled sometime today, so they now had the pain medication in the facility. During an interview on 12/18/24 at 3:40 P.M., LPN F said staff had ordered pain medication for the E kit and knew it was supposed to be delivered sometime today. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 12/18/24 at 3:51 P.M., LPN G said there was a crazy process to get prescriptions filled from their new pharmacy. Staff had to call the pharmacy. The pharmacy then sent a fax to the physician's office and the physician sent it back to the pharmacy. It was kind of a difficult process. It had been a process to try and get medications filled. During an interview on 12/18/24 at 4:26 P.M., the DON, the Administrator, and the Corporate Nurse said staff should request a refill when medications reach seven days remaining. If staff couldn't get medication, staff should call for a new script. If staff couldn't get it in a timely manner, staff should request an alternative. If something was unavailable, then staff should contact the physician. The DON thought the pharmacy delivered the E kit replacement at around 1:15 P.M., on 12/18/24. The DON and the Administrator said staff should be assessing residents for pain every shift, on admission, readmission and with a change of condition and as needed. During an interview on 12/19/24 at 10:45 A.M., Pharmacist J said the new script for Resident #2's pain medication left the pharmacy this morning to be delivered. During an interview on 01/02/25 at 9:40 A.M., Pharmacist L said if the facility requested a refill and the scripts were received by 12:00 P.M., then the pharmacy could send the medication out to the facility the same day. For E kit medications, the facility had to fill out a form for certain medications they wanted ordered and the pharmacy could deliver it the same day if placed by 12:00 P.M. If the facility needed medications STAT, then the pharmacy would try to deliver it the same day if possible. If a resident was without pain medication, the resident would probably be in pain and depending on the amount of pain, the facility may need to contact a physician to see if they wanted to try something different until the resident's normal pain medication was available again.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49152 Based on observation, interview, and record review, the facility failed to ensure residents received required physician's visits for one resident (Resident #3) out of five sampled residents. The facility census was 94. Review of the facility policy titled, Physician Services Guidelines, last revised 03/10/23, showed: - The physician must make an initial comprehensive visit no later than 30 days after admission; - A physician must visit the patient at last every 30 days for the fist 90 days after admission and at least every 60 days thereafter. 1. Review of Resident #3's medical record showed: - admitted on [DATE]; - Diagnoses of falls, acute kidney failure (kidneys not functioning properly), chronic pain, reduced mobility, muscle weakness, cognitive communication deficit (condition making it difficult to communicate with someone), aphasia (difficulty speaking), hypothyroidism (abnormal thyroid hormone), hypertension (high blood pressure, gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), bilateral osteoarthritis (joint disease), and a colostomy (procedure creating opening to intestines through abdomen allowing stool to exit the body); - No documented physician or care provider visit; - A progress note, dated 12/11/24 at 3:37 P.M., showed a conversation with the family related to the appointment made with an outside primary care provider (PCP) on 12/12/24. The family was educated this PCP did not follow patients in this nursing home and the facility physician would see the resident. The family wished to keep the appointment. The PCP's office made aware the patient was currently in a skilled facility; - The resident attended the outside PCP appointment setup by family on 12/12/24. During an interview on 12/17/24 at 9:45 A.M., Resident #3 said he/she had not seen a physician at the facility. He/She wanted to see his/her physician outside the facility but was told by the facility staff he/she was not allowed and had to seen by the facility physician. Finally, on 12/12/24, he/she went to see his/her PCP outside the facility. During a phone interview on 12/18/24 at 11:50 A.M., the resident's family said that the facility physician hadn't seen the resident since being admitted to the facility, so he/she scheduled an appointment with a physician outside the facility. The facility said the resident could not see a different physician and the facility physician would see the resident. The facility tried to get the family to cancel the physician's appointment on 12/12/24, but the family refused. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 3:32 P.M., Registered Nurse (RN) E said the facility's previous physician left on 11/17/24, and the new facility physician started to visit some of the residents on 12/10/24. He/She didn't know which residents the physician saw. During an interview on 12/18/24 at 3:40 P.M., Licensed Practical Nurse (LPN) F said the facility physician rounded on 12/10/24, but only saw newly admitted residents. During an interview on 12/18/24 at 3:51 P.M., LPN G said the new facility physician rounded on some of the residents for the first time on 12/10/24. He/She didn't know who the physician saw. During a phone interview on 12/18/24 at 12:35 P.M., the physician's office RN K said Resident #3 wasn't seen by the facility physician on 12/10/24, when the physician was at the facility. He/She believed the physician only saw newly admitted residents that day. He/She didn't not know when the physician would be back at the facility. During an interview on 12/18/24 at 4:30 P.M., the Director of Nursing (DON) and the Administrator said the residents should be seen by a physician every 30 days for the first 90 days after being admitted .