

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42592</p> <p>Based on observation, interview and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice when staff failed to ensure ordered medications were available for administration for two residents (Resident #15 and #17), in a review of 20 sampled residents. In addition, the facility failed to follow discharge instructions for pain medication after an emergency room visit for one resident (Resident #20). The facility census was 180.</p> <p>Review of the facility's policy, Transcription of Orders/Following Physician's Orders, revised 05/18/24, showed the following:</p> <ul style="list-style-type: none"> -The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders; -Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in residents' electronic medical records in orders section; -The Licensed/Registered Nurse will check the emergency kit to verify if the medication is present in the facility to begin immediately. If the medication is not available, the facility may contact the backup pharmacy to deliver the medication sooner; -The Licensed Nurse will review electronic Medication Administration Records (MARs) & electronic Treatment Administration Records (TARs) on a routine basis to monitor for medications that were not administered to the resident due to unavailability, refusal, omission, etc; -If the medication is unavailable, the Licensed Nurse will contact the pharmacy and have the medication delivered. If the resident is not going to receive their scheduled medication per Physician's Order, the Licensed Nurse will contact the Director of Nursing, the Administrator, Physician and Legal Guardian, if applicable. The Resident Care Coordinator (RCC)/Unit Manager/Designated Nurse will then follow any further orders that may be provided by the Physician. The facility may utilize a stat or emergency medication kit or back up pharmacy to deliver the medication to the resident before the primary pharmacy is able to deliver; <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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The Nurse or CMT in charge of medication administration must review all their designated MARs and TARs prior to the end of their shift to ensure that all medications/treatments scheduled to be given on their shift were administered according to the physicians' order and that all necessary interventions were taken in the event of an omission;</p> <p>-The RCC/Unit Manager/Designated Nurse will review all electronic MARs/TARs and compare all medications to the medications available for each resident in the facility weekly to ensure availability.</p> <p>Review of the facility's policy, Medication Administration, revised 06/26/24, showed medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. It is the policy of this facility to ensure the safe and effective administration of all medications by utilizing best practice guidelines.</p> <p>1. Review of Resident #15's undated face sheet showed diagnosis of type II diabetes mellitus (a medical condition in which too much sugar is in the bloodstream) and hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone).</p> <p>Review of the resident's care plan, revised 09/20/24, showed the following:</p> <p>-He/She has an active history of diabetes mellitus type II with long-term use of insulin (injectable medication to treat diabetes);</p> <p>-Diabetes medication as ordered by the physician;</p> <p>-Educate regarding medications and importance of compliance.</p> <p>Review of the resident's December 2024 Physician Order Sheet (POS) showed the following:</p> <p>-Novolog (fast-acting insulin), inject subcutaneously (fatty tissue beneath the skin) before meals, inject as per sliding scale: if blood sugar is 61-150 give eight units, if 151 - 180 give 10 units, if 181 - 220 give 12 units, if 221 - 340 give 14 units, if 341 - 350 give 16 units; order start date of 09/19/24;</p> <p>-Ozempic (injectable medication used to treat type II diabetes) inject 2 milligrams (mg) subcutaneously on day shift every Friday;</p> <p>-Toujeo Solostar subcutaneous pen-injector (long-acting insulin), inject 30 units subcutaneously in the morning;</p> <p>-Toujeo Solostar subcutaneous pen-injector, inject 70 units subcutaneously at bedtime.</p> <p>Review of the resident's December 2024 MAR and MAR administration notes showed the following:</p> <p>-On 12/06/24, day shift pass, Ozempic 2 mg not administered by Certified Medication Technician (CMT) C due to medication not available; will follow-up with pharmacy;</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 12/06/24, 8:00 A.M. medication pass, Toujeo Solostar 30 units not administered by CMT C due to medication not available; will follow-up with pharmacy;</p> <p>-On 12/06/24, 8:00 P.M. medication pass, Toujeo Solostar 70 units not administered by CMT C due to medication not available; will follow-up with pharmacy;</p> <p>-Blood sugar values for 12/06/24 were 180 at 8:00 A.M., 130 at 12:00 P.M. and 217 at 5:00 P.M. (optimal blood sugar range is between 70 and 100);</p> <p>-On 12/07/24, 8:00 P.M. medication pass, Toujeo Solostar 70 units not administered by CMT D due to out of insulin;</p> <p>-No documentation staff notified the resident's physician related to missing scheduled Ozempic and Toujeo on 12/06/24 or 12/07/24.</p> <p>Review of the resident's nursing progress notes showed no documentation the resident's physician, Director of Nursing (DON) or administrator were notified (per policy) of the resident missing his/her scheduled Ozempic and Toujeo medications on 12/06/24 and 12/07/24. The medications were not available in the facility stat/emergency kit. There was no documentation the Licensed/Registered Nurse contacted a backup pharmacy for either medication as the facility policy instructed.</p> <p>Review of the resident's nursing progress notes, dated 12/09/24 at 4:24 P.M., showed the Interim DON documented the following:</p> <p>-Primary care physician notified of medication concern, with no indication of what medication or concern;</p> <p>-Medication placed on hold at this time, with no indication of what medication was put on hold;</p> <p>-Pharmacy contacted and said medication would be delivered on the night run, with no indication of what medication was to be delivered.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 12/22/24, showed the following:</p> <p>-Cognitively intact;</p> <p>-No rejection of cares;</p> <p>-Takes daily insulin injections.</p> <p>Review of the resident's December 2024 MAR and MAR administration notes showed on 12/27/24 at the 8:00 P.M. medication pass, Toujeo Solostar 70 units not indicated as administered as the entry was blank.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's nursing progress notes showed no documentation the resident's physician, DON or Administrator were notified (per policy) of the resident missing his/her scheduled Toujeo medication as ordered on 12/27/24. The medication was not available in the facility stat/emergency kit. There was no documentation the Licensed/Registered Nurse contacted a backup pharmacy as the facility policy instructed.</p> <p>Review of the resident's January 2025 POS showed the following:</p> <ul style="list-style-type: none"> -Levothyroxine sodium (thyroid replacement hormone) 25 micrograms (mcg) by mouth in the morning; -Novolog, inject subcutaneously before meals, inject as per sliding scale: if blood sugar is 61-150 give eight units, if 151-180 give 10 units, if 181-220 give 12 units, if 221-340 give 14 units, if 341-350 give 16 units; order start date of 09/19/24; -Ozempic inject 2 mg subcutaneously on day shift every Friday; discontinued on 01/09/25 at 4:18 P.M.; -Toujeo Solostar subcutaneous pen-injector, inject 30 units subcutaneously in the morning; discontinued on 01/09/25 at 3:27 P.M.; -Toujeo Solostar subcutaneous pen-injector, inject 70 units subcutaneously at bedtime; discontinued on 01/09/25 at 3:29 P.M.; -Lantus Solostar subcutaneous pen-injector, inject 30 units subcutaneously in the morning; start date of 01/10/25; -Lantus Solostar subcutaneous pen-injector, inject 70 units subcutaneously at bedtime; start date of 01/09/25. <p>Review of the resident's January 2025 MAR and MAR administration notes showed the following:</p> <ul style="list-style-type: none"> -On 01/01/25 at 5:00 A.M. medication pass, levothyroxine sodium 25 mcg not indicated as administered as the entry was blank; -On 01/06/25 at 5:00 P.M. blood sugar check, sliding scale not indicated as obtained as the entry was blank; -Blood sugar value for 01/07/25 at 8:00 A.M. was 93; -On 01/07/25 at 8:00 A.M. medication pass, Toujeo Solostar 30 units not administered by CMT E due to medication not available; on order with pharmacy; -Blood sugar value for 01/07/25 at 12:00 P.M. was 112; -On 01/07/25 at 5:00 P.M. blood sugar check, sliding scale not indicated as obtained as the entry was blank; <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She tried to reorder when a week was left of the medication, so the resident did not run out;</p> <p>-If a resident runs out of medication, he/she let the charge nurse know via text or call, as well as the RCC, DON and Assistant Director of Nursing (ADON); he/she did not document the notifications;</p> <p>-When a medication was not available, he/she calls the pharmacy to request the medication;</p> <p>-The resident had run out of Toujeo and Ozempic a couple of times;</p> <p>-He/She did not call the physician when a medication was out and left that up to the nurses.</p> <p>During an interview on 01/14/25, at 9:45 A.M., CMT E said the following:</p> <p>-He/She worked the night shift during the month of December and just recently transferred to day shift;</p> <p>-If a medication was not available for administration, he/she would notify the charge nurse;</p> <p>-He/She did not notify the DON or RCC any time he/she worked night shift as they did not work at the same time he/she worked;</p> <p>-He/She does not call the pharmacy for a missing medication, but calls the charge nurse to let him/her know so they can call the pharmacy; he/she does not document this call;</p> <p>-If there was a blank spot on the MAR, that indicated the medication was not given;</p> <p>-Recently there had been an insurance issue with the resident's Toujeo and it was changed to Lantus.</p> <p>During an interview on 01/09/25 at 3:19 P.M., Licensed Practical Nurse (LPN) A said the following:</p> <p>-The resident ran out of Toujeo;</p> <p>-If a medication was not available to give, the physician and RCC should be notified;</p> <p>-He/She could not recall if he/she had specifically called the physician or RCC related to the resident's Toujeo;</p> <p>-The resident was still out of Toujeo, and he/she had not called the pharmacy and could not recall if the RCC, physician or DON had been notified.</p> <p>During an interview on 01/09/25 at 3:55 P.M. and 01/16/25 at 11:39 A.M., the RCC said the following:</p> <p>-Staff had not notified her and she was unaware that the resident was out of Toujeo;</p> <p>-There had been issues with getting the Toujeo from pharmacy due to the medication being on back order, she was not aware of any insurance issues directly related to the Toujeo;</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-She would expect to be notified by staff if a resident's medications were not available and not able to be given, so the pharmacy could be notified, or the physician notified for additional orders;</p> <p>-Per policy, the licensed nurse was responsible for reviewing the electronic MARs/TARs weekly to monitor for unavailable medications or any other medication issues;</p> <p>-Night shift nurses were designated to do the reviews.</p> <p>During an interview on 01/14/25 at 1:10 P.M., the resident's physician said the following:</p> <p>-He would expect medication to be administered as ordered;</p> <p>-If a medication was unavailable for administration, he would expect staff to call him for an alternative order;</p> <p>-He did not recall being notified of the resident's missing Toujeo, Ozempic or levothyroxine in the past;</p> <p>-He recently changed the Toujeo to Lantus at the request of staff and the resident; he did not know what the issue was; he would have changed it at any time if he would have been notified; anytime something could not be obtained from pharmacy there was always something that could be changed.</p> <p>2. Review of Resident #17's undated face sheet showed a diagnosis of chronic pain.</p> <p>Review of the resident's care plan, revised 04/17/24, showed the following:</p> <p>-The resident has chronic pain related to depression;</p> <p>-Provide the resident with information about pain and options available for pain management. Discuss and record preferences.</p> <p>Review of the resident's annual MDS, dated [DATE], showed the following:</p> <p>-Cognitively intact;</p> <p>-No behaviors or rejection of care;</p> <p>-No pain management program: no scheduled pain medications, as needed pain medications or non-medication interventions for pain;</p> <p>-Pain was occasionally present, occasionally affects sleep, occasionally interferes with day-to-day activities and has a rated pain of six on a 0-10 pain scale.</p> <p>Review of the resident's January 2025 POS showed an orders for lidocaine external patch (topical pain application that eases pain by numbing the nerves and making them less sensitive to pain) 4%, apply to lower back topically in the morning for back pain;</p> <p>Review of the resident's January 2025 MAR and MAR administration notes showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 01/06/25 at the 8:00 A.M. medication pass, lidocaine patch not applied by CMT E due to medication not available. Medication on order with pharmacy;</p> <p>-On 01/07/25 at the 8:00 A.M. mediation pass, lidocaine patch not applied by CMT E due to medication not available; on order with pharmacy.</p> <p>-No indication staff notified the physician related to missing scheduled lidocaine patch applications as ordered on 01/06/25 or 01/07/25.</p> <p>Review of the resident's nursing progress notes showed no documentation the resident's physician, DON or Administrator were notified (per policy) of the resident missing his/her scheduled lidocaine patch applications as ordered on 01/06/25 or 01/07/25. The medication was not available in the facility stat/emergency kit. There was no documentation the Licensed/Registered Nurse contacted a backup pharmacy as the facility policy instructed.</p> <p>During an interview on 01/08/25 at 9:55 A.M., the resident said the following:</p> <p>-He/She has not been getting his/her lidocaine patch for the past few days because staff said they were out;</p> <p>-His/Her lidocaine patches run out frequently;</p> <p>-His/Her back hurts every day and he/she needed the patches;</p> <p>-Nothing else had been done about his/her pain.</p> <p>During an interview on 01/14/25 at 9:45 A.M., CMT E said recently there has been an issue with the resident running out of lidocaine patches.</p> <p>During an interview on 01/09/25 at 3:55 P.M., the RCC said she was unaware the resident had run out of lidocaine patches at any time.</p> <p>3. Review of Resident #20's undated face sheet showed the following:</p> <p>-Admission to the facility on [DATE];</p> <p>-Diagnoses included sciatica (pain radiating along the sciatic nerve, which runs down one or both legs from the lower back) and chronic pain syndrome (persistent pain that lasts weeks to years).</p> <p>Review of the resident's care plan, revised on 11/14/24, showed the following:</p> <p>-The resident was on pain medication therapy related to pain;</p> <p>-Administer analgesics (pain) medication as ordered by the physician;</p> <p>-The resident has chronic pain.</p> <p>Review of the resident's nursing progress notes showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 12/30/24 at 3:20 P.M., the RCC documented she went to change the dressing on the resident's left lower leg. Area had significant drainage with redness around the open area. Primary care physician (PCP) notified, new order to send to the hospital for treatment and evaluation;</p> <p>-On 12/30/24 at 5:50 P.M., the RCC documented the resident returned from local hospital with new order to clean wound twice a day with antibacterial soap and water, pat dry, and apply xeroform (a wound dressing) with gauze dressing and an order for hydrocodone-acetaminophen (narcotic pain medication), 5-325 mg every four hours as needed times 18 pills (no stop or discontinue date indicated).</p> <p>Review of the resident's hospital discharge instructions, after emergency room evaluation on 12/30/24, showed the following:</p> <p>-The resident was treated for worsening of condition, a leg wound;</p> <p>-An order for hydrocodone-acetaminophen 5-325 mg, one tablet by mouth every four hours as needed for pain for a total of 18 tablets, no refills (no stop or discontinue date indicated);</p> <p>-A physical prescription order for hydrocodone-acetaminophen 5-325 mg, take one tablet by oral route every four hours as needed for pain, dispense 18 tablets with no refills;</p> <p>-Documentation showed the resident discharged back to the facility at 5:50 P.M.</p> <p>Review of the resident's December 2024 POS showed the following:</p> <p>-Hydrocodone-acetaminophen 5-325 mg, give 1 tablet by mouth every four hours as needed for pain related to chronic pain syndrome for five days, 18 pills total (the hospital discharge orders noted no instruction related to five days); order date of 12/30/24 and discontinued on 12/31/24; no documentation as to what staff entered or discontinued the order.</p> <p>Review of the resident's December 2024 MAR, completed by CMT staff, showed the following:</p> <p>-An order for hydrocodone-acetaminophen 5-325 mg, one tablet by mouth every four hours as needed for pain related to chronic pain syndrome for five days, with an order start date of 12/30/24;</p> <p>-No documentation staff administered hydrocodone-acetaminophen on 12/30/24;</p> <p>-No documentation staff administered hydrocodone-acetaminophen on 12/31/24;</p> <p>-The resident's ordered hydrocodone-acetaminophen 5-325 mg, one tablet by mouth every four hours as needed for pain related to chronic pain syndrome for five days (discrepancy from hospital discharge orders), with an order start date of 12/30/24, was documented as discontinued on 12/31/24 (no time indicated and no documentation of what staff entered the medication as discontinued).</p> <p>Review of the resident's medical record, including the nursing progress notes, showed no documentation related to staff obtaining an order to discontinue the resident's hydrocodone-acetaminophen on 12/31/24.</p> <p>Review of the resident's January 2025 POS showed the following:</p> <p>(continued on next page)</p>		

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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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Meloxicam 15 mg 1 tablet by mouth one time a day related to sciatica;</p> <p>-Tizanidine HCL 4 mg, give two tablets by mouth four times a day for muscle spasms;</p> <p>-No documentation of an order for hydrocodone-acetaminophen 5-325 mg.</p> <p>During an interview on 01/08/25 at 1:25 P.M. and 01/09/25 at 3:55 P.M., the resident said the following:</p> <p>-All of his/her as needed pain medication had been discontinued and he/she did not understand why;</p> <p>-He/She was in discomfort every day and could not take anything additional for it;</p> <p>During an interview on 01/09/25, at 2:16 P.M., the Interim Director of Nursing (DON) said the following:</p> <p>-Physician orders should be followed as written;</p> <p>-If a medication runs out, she expects the staff to call the pharmacy and get it sent out on the next run;</p> <p>-If a resident is unable to get their medication, the physician should be contacted for additional orders;</p> <p>-She would expect the staff to keep track of the medication status and reorder before it runs out;</p> <p>-She would expect staff to notify her or the RCC if a medication is unable to be given due to not being available;</p> <p>-If a MAR was blank in the administration box, it is an indication that the medication probably was not given</p> <p>-She was unsure why the hydrocodone-acetaminophen was discontinued for Resident #20.</p> <p>During an interview on 01/09/25 at 5:10 P.M., the administrator said the following:</p> <p>-If a resident reported they were not getting their medication as order, he would expect staff to look into the report and if necessary, get a hold order, stop order or new medication;</p> <p>-He was unaware of anyone missing their medication, but nursing takes care of that;</p> <p>-Physician orders should be followed as written if at all possible.</p> <p>MO245897</p> <p>MO246214</p> <p>MO246359</p>