STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265369	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Oaks	1500 Calvary Church Road Festus, MO 63028

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32751 Based on interview and record review, the facility failed to ensure one resident (Resident #1) of three sampled residents was free from significant medication error when staff failed to verify the medication administered correlated to the physician's orders for 16 doses of a high alert (medication that bears a heightened risk of causing significant patient harm when they are used in error) chemotherapy medication (treatment that uses powerful chemicals to kill fast-growing cells in your body) which resulted in increased pain and multiple infections due to the properties of the medication and toxicity. The resident died as a result. The facility census was 118. The administrator was notified on [DATE] at 3:30 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor onsite verification. Record review of the facility's Administering Medications Policy dated [DATE] showed: - Medications are administered in accordance with the prescriber orders, including any time frame; - If a dosage is considered to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected with being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician of the facility's medical director to discuss the concerns; - The individual administering the medications will verify the resident's identity before giving the resident his/her medications by: a) checking arm, band, b) checking photograph in the medical record, and c) if necessary, verify resident identification with other facility personnel; - The individual administering the medication will check the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method of administration before giving the medication. The facility did not provide a policy regarding the process for accepting medications in from the pharmacy or for reconciling medications received to physician's orders. 1. Review of Resident #1's Physician Order Sheet (POS) dated [DATE] showed: - An admitted [DATE]; (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Diagnosis included Congestive Heart Failure (CHF) (a chronic condition in which the heart does not pump properly); - An order for Metolazone (a blood pressure medication) 2.5 milligram (mg) for treatment of CHF; - No diagnosis for cancer or treatment of cancer. Record review of the resident's facility progress notes showed: - On [DATE], the resident admitted to the facility alert, oriented, continent and ambulatory; - On [DATE], the resident found to be cognitively impaired; - On [DATE], the resident appeared to have no interest or pleasure in doing anything; - On [DATE], the resident developed an abdominal rash. Staff notified the physician who ordered an antibiotic and skin cream; - On [DATE], the resident exhibited shortness of breath and swelling in lower extremities; - On [DATE], the resident developed wounds to the tongue, chest, right lateral thigh, groin, left foot, right foot, and back; - On [DATE], an X-ray was done and showed lungs to be clear; - On [DATE], lesions had developed and the physician ordered the resident be sent to the emergency room . On the same date, the pharmacy contacted the facility to alert them to a medication error. The pharmacy had sent Methotrexate (a high alert chemotherapy drug) instead of the resident's prescribed Metolazone (blood pressure pill). Review of Resident #1's Medication Administration Record (MAR) dated February 2024 and [DATE] showed: - Metolazone 2.5 mg administered on [DATE], [DATE], [DATE], and [DATE] through [DATE]; - Metolazone 2.5 mg administered a total of 16 times for February and [DATE]. Record review of the facility's investigation dated [DATE] showed: - On [DATE], the facility received a call from the pharmacy alerting staff they had sent the wrong medication for Resident #1; - The facility started an investigation and documented the resident had an order for Metolazone and the medication card provided by the pharmacy was Methotrexate; - The card showed 16 doses of Methotrexate had been administered by multiple facility staff members beginning [DATE]; (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On [DATE], the facility notified the hospital, family and physician of the medication error; - The physician suspected the skin issue was due to the medication error as a result of Methotrexate toxicity; - The resident passed away in the hospital on [DATE]. Record review of the hospital records showed: - The resident was admitted on [DATE] with open wounds and bruises all over the body; - On [DATE], the resident had further decline with blood coming from the mouth, fallen platelets and a diagnosis of coagulopathy (a disorder of the blood preventing clotting); - On [DATE] the resident passed away. Observation on [DATE] at 10:30 A.M., showed a medication card for Resident #1, labeled Methotrexate with 16 doses missing. During an interview on [DATE] at 10:30 A.M., the Director of Nurses (DON) said the facility has a policy regarding the administration of medications. She said when medications are delivered from the pharmacy, the staff on the floor will check them in using the receipt provided by the pharmacy and the actual medication card provided by the pharmacy. They are only verifying the cards are all accounted for. The staff member is not aware of what has been ordered at this point, so would not have known that Methotrexate was wrong. She said when the medications are checked into the cart, the staff member should have caught the error. She said they do not sign off as they check in the medication, so the facility did not know who checked in the medication. The DON said nursing staff are trained and aware of the proper way to administer medications. Staff are expected to verify the medications and the orders by looking at MAR, POS, and medication card to verify the right medication and right dosage. Four Certified Medication Technicians (CMTs) administered the methotrexate to Resident #1 over the course of 16 days. No one caught the error. She said she can't imagine how they missed it and did not see the wrong medication name on the card. During an interview on [DATE] at 11:40 A.M. CMT A said he/she has been a CMT for several years and was trained in the proper way to administer medications. CMT A said this had never happened before. The name of the medication on the card and the accurate medication are close in spelling. He/she said it was a mis-read card. He/she had no explanation as to why the error was not caught prior to administering 16 doses. During an interview on [DATE] at 1:00 P.M., CMT B said he/she has no idea what happened. He/she tries to be diligent and verify medications are correct prior to administration. He/she is aware of policy, but did not read the card accurately prior to administering the medication. He/she had no explanation as to why the error was not caught prior to administering 16 doses. During an interview on [DATE] at 1:30 P.M., CMT C said the facility had recently changed pharmacies and the incident was just an oversight. The medication name on the card and on the POS were close in spelling. He/she said they may have just glanced rather than read the card. He/she had no explanation as to why the error was not caught prior to administering 16 doses. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:35 P.M., CMT D said he/she only works as needed and had no idea how the error was not caught sooner. He/she is aware of the facility policy. CMT D said it was just mis-read. He/she had no explanation as to why the error was not caught prior to administering 16 doses. During an interview on [DATE] at 2:45 P.M., the pharmacy representative said they caught the error in the medication and told the facility on [DATE]. The error was caught on the pharmacy side while preparing the order for the next month for Resident #1. The representative had no explanation as to why the error was not caught sooner. During an interview on [DATE] at 11:25 A.M., the facility physician said Methotrexate is a chemotherapy type drug used only under strict physician monitoring. She said it is usually given weekly and the facility gave it to Resident #1 daily for over two weeks. The side effects the resident experienced are consistent with the toxicity level high doses of this medication would cause. The resident would have experienced pain and the breakdown of skin cells from the inside out. This caused the resident's death. The physician said Resident #1 was alert and oriented and had a good quality of life when he/she entered the facility. The physician said she expected staff to follow prescription order and to follow standards of practice when administering medications. She said there is no excuse or explanation for administering the wrong medication 16 times. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). Complaint #MO233181 and 233193