

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/29/2025
NAME OF PROVIDER OR SUPPLIER  Shepherd of the Hills Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  996 State Highway 248 Branson, MO 65616	

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 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.  (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interview, the facility failed to ensure pharmacy services in place that established a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, that ensured drug records were in order, and ensured an account of all controlled drugs was maintained and periodically reconciled when staff had medications that could not be returned to the pharmacy stored and not destroyed in timely manner for 73 residents, which included 159 cards of controlled substance medications, and failed to have a system of accountability for the 159 cards of unused controlled substance medications located in locked cabinets in two offices that were pending destruction. The facility census was 69. Review of the facility policy titled Destruction of Medications, undated, showed the following: -The facility will destroy and dispose of medication in a safe manner and in accordance to applicable law; -All medication not returned to the issuing pharmacy will be destroyed; -Two licensed nurses or one licensed nurse and the facility pharmacist will destroy all medications, except controlled substances which will require Director of Nursing (DON) supervision; -Documentation of medication destruction will include date, name of medication, prescription (RX) number, amount of medication to be destroyed, method of destruction, and signatures of nurses and/or pharmacist; -Scheduled II to IV medications (under the Controlled Substances Act, have a potential for medication abuse) will be destroyed as stated above with the following exceptions: -The controlled medication count sheet will include the following information: -Signature of nurses and/or pharmacist destroying the medication; -Amount destroyed and date destroyed. Review of the facility policy titled Discontinued Medications, undated, showed the following: -When the attending physician discontinued a medication, it must be recorded in the resident's medical record and medication sheet; -The staff or charge nurse receiving the order to discontinue a medication is responsible for charting such information and must also notify the issuing pharmacy of such order; -The facility and/or the issuing pharmacy may destroy discontinued medications; -When medications have been discontinued and are not to be returned, refer to medication destruction guidelines; -The following will be the protocol for controlled medications: -When a medication has been discontinued, the nurse or certified medication technician (CMT) will discontinue the controlled medication on the physician order sheet (POS) and medication administration record (MAR); -The nurse or CMT will document the amount of controlled medication to be discontinued on the MAR; -The nurse or CMT will then log the controlled medication on the individual resident's destruction record to include the following Information: -Date medication discontinued, Rx number, and amount left on card or left in bottle; -The controlled medication will then be placed in the locked cabinet for destruction; -The controlled medication sheet will be maintained in the narcotic book under the discontinued narcotic tab and will be counted until destroyed; -When narcotics are destroyed, the nurses will document on the destruction record and narcotic records date destroyed, how medication was destroyed, and both nurses' names and titles; -Controlled medications will be destroyed at least weekly with DON supervision. 1. Review of Resident #1's medical record showed the following: -admission date of 02/22/25; -discharge date of 04/15/25; -Diagnoses included cerebral infarction (stroke), traumatic brain injury (TBI - damage to the brain caused by an external force, such as a bump, blow, jolt, or penetrating injury to the head), and chronic pain syndrome (persistent pain lasting longer than three months). Review of the resident's nursing notes dated 04/15/25, at 2:43 P.M., showed staff documented the resident was discharged home with his/her spouse via private vehicle with all of his/her possessions at 1:50 P.M. Discharge paperwork signed, and copies sent home with him/her along with all of his/her available medications. No new skin issues noted. He/she left with all his/her personal belongings. Nothing has been reported missing. Review of the resident's February 2025, March 2025, and April 2025 MARs showed the following: -An order, dated 02/26/25, for oxycodone (controlled drug used to treat moderate to severe pain) 15 milligrams (mg), administer one table every eight hours as needed for pain; -Staff documented administration of oxycodone medication almost every day with last dose administered on 04/14/25 at 8:52 P.M. Review of the resident's documents tab in the electronic medical record showed the following: -A Controlled Drug Receipt, Record, and Disposition form, dated 02/27/25, for oxycodone 15 mg tablets, 30 tablets dispensed. Staff documented administration of the medication from 02/28/25 through 03/16/25; -A Controlled Drug Receipt, Record, and Disposition form, dated 03/04/25, for oxycodone 15 mg tablets, 30 tablets dispensed. Staff documented administration of the medication from 03/17/25 through 04/04/25. -No Controlled Drug Receipt, Record, and Disposition Form for</p>		