

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/30/2026
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure all medication was secured when medication and treatment carts were left unlocked, medication keys were left in box on top of the medication cart, and keys were left in the door lock of the medication room. The facility census was 77. Review of the facility policy, titled Storage of Medication, dated July 2021, showed the following: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier; The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, pharmacy personnel, or staff members lawfully authorized to administer medications; Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. 1. Observation of the 300/400 Hall nurses' desk on 07/29/26 at 9:28 A.M., showed the following: No nurses/staff at the nurse's desk; The medication room was located behind the nurse's desk; The medication room keys were in the lock of the medication room door, visible to anyone walking by the desk; The 300 and 400 hall treatment carts were located in the short hallway between the resident hall and the resident activity room, around the corner from the 300/400 hall nurse's desk; Both carts were unlocked and unattended by staff; The carts contained resident treatment supplies, including bandages and prescription ointments and creams; An open caddy on top of the treatment cart contained toothbrush holders containing resident insulin pens. Observation of the 300/400 Hall nurses' desk on 07/29/26 at 9:30 A.M., showed the following: Licensed Practical Nurse (LPN) H approach the nurse's desk where two medications carts were located on the outside of the desk (between the 300 and 400 resident hallways); LPN H said he/she needed to administer pain medication to a resident; LPN H removed a set of keys from an open pocket on the outside of a soft side cooler located on the top of the medication cart; LPN H used the keys to unlock both the medication cart and the controlled medication locked drawer, which contained various controlled substances, including resident narcotic pain medication; LPN H returned the keys to the open pocket on the outside of the soft side cooler; LPN H administered the pain medication, relocked the cart and walked away from the cart leaving the keys unsecured in the cooler. Observation of the 300/400 Hall nurses' desk on 07/29/26 at 9:43 A.M., 10:00 A.M., and 10:30 A.M., showed the following: No nurses/staff at the 300/400 hall nurse's desk; The medication room was located behind the nurse's desk; The medication room keys were in the lock of the medication room door visible to anyone walking by the desk; The 300 and 400 hall treatment carts were located in the short hallway between the resident hall and the resident activity room, around the corner from the 300/400 hall nurse's desk; Both carts were unlocked and unattended by staff; The carts contained resident treatment supplies, including bandages and prescription ointments and creams; An open caddy on top of the treatment cart contained toothbrush holders containing resident insulin pens. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265393 If continuation sheet Page 1 of 4

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the 300/400 Hall nurses' desk on 07/29/26, at 12:10 P.M., showed the following:-Two unlocked medication carts in the common area near the dining room, the drawers could be opened without a key;-Two Certified Medication technicians (CMT) staff in the dining room with residents providing medications;-One resident in the common area near the medication carts, self-propelling in a wheelchair;-CMT G returned to the cart and prepared medications, he/she then pushed the lock halfway and returned to the dining room, the cart could be opened without a key;-CMT F returned to the cart and prepared medications, he/she returned to the dining room and did not lock the cart. During an interview on 07/29/26, at 1:05 P.M., CMT F said medication carts should be locked any time staff step away from the cart. He/She said medication carts should not be partially locked. During an interview on 07/29/26, at 2:35 P.M., LPN D said the following:-Keys were in the medication room door, however the room only contains the emergency medication kit, but the kit is locked;-The medication carts were unlocked when they were at the nurses' station;-Some CMT staff always keep the keys with them, and some staff leave the keys in a container on the top of the cart;-The carts should be locked when staff are not nearby. During an interview on 07/29/26 at 1:37 P.M., the Director of Nursing (DON) said the following:-Nurses and CMT's should keep the medication carts, controlled medications drawer, the medication room door, and the treatment carts locked when not in use;-Nurses or CMTs are responsible for medications and should keep the keys on their person;-Some of the staff leave the medication cart keys in the pocket of cooler bag on top of the cart. Staff have had issues with accessing resident medication when a staff leaves for break and forgets to leave the keys;-The medication room keys are a different set of keys and the nurse on duty should keep those on his/her person;-Medication room keys should not be left in the door, as that could potentially allow medication room access to a visitor or other employee who should not have access;-The nurses should ensure the treatment carts are locked when not in use and should not leave insulin pens on top of the treatment cart unattended. This could lead to someone potentially tampering with or stealing resident insulin pens or treatments supplies. During an interview on 07/29/26 at 2:36 P.M., LPN D said the following:-Nurses regularly leave the keys in the medication room doors;-The nurses always leave the treatment carts unlocked and leave the resident insulin pens on top of the cart;-Some of the CMTs leave the medication cart keys in the cooler bag on top of the carts;-When staff leave the carts unlocked, or keys in the medication room door, a resident, visitor, or another staff member could potentially take the resident medication;-He/She is unaware of the regulations regarding control of resident medications/controlled medications. During an interview on 07/29/26 at 3:18 P.M. CMT I said the following:-Nurses and CMTs should keep the medication and treatment carts locked at all times when not in use;-The nurses and CMTs who are responsible for the carts and medication room should keep the keys in their pockets;-If a staff member leaves the facility, they should give the keys to the nurse on duty before leaving;-Insulin should be stored in the medication room. During an interview on 07/30/26 at 1:53 P.M., the Administrator said the following:-Nurses and CMTs should ensure all medication rooms, medication carts, and treatment carts are kept locked and they should keep keys secure on their person.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview the facility failed to document notification of the responsible party or emergency contact of the resident's change in health condition, transfer to and return from the hospital for one Resident (Resident #1). The facility census was 77. Review of the undated facility policy, titled Condition Change, Resident, showed the following:-After all resident falls, injuries of changes in physical or mental function, monitor the resident;-Notify the resident's responsible party;-Monitor resident's condition frequently;-Notify physician of condition change, need for treatment orders and/or medication order changes. Review of the undated facility policy, titled Charting and Documentation, showed the following:-Chart all pertinent changes in the resident's condition, as well as routine observations;-Any transfers, including to the hospital, should include date and time transfer was made, reason for the transfer, dated and time the family was notified and by whom, location and mode of transfer, resident's response to the transfer, all pertinent observation;-Other documentation should include any time the physician or family is called about the resident as well as their response. 1. Review of Resident #1's face sheet (brief information sheet about the resident) showed the following:-admission date of 01/14/25;-Diagnoses included: Dementia (decline in mental ability severe enough to interfere with daily life) with anxiety, repeated falls, acute cerebrovascular insufficiency (sudden drop in blood flow to the brain caused by blocked arteries or low blood pressure), paroxysmal atrial fibrillation (an irregular and often very rapid heart rate that can lead to blood clots in the heart);-Two emergency contacts listed with name and phone number. Review of the resident's care plan, last updated 04/16/26, showed no information regarding family or emergency contact. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 05/22/26, showed the resident has a moderate cognitive impairment. Review of the resident's nursing notes for June 2026, showed the following:-On 06/18/26 at 2:42 P.M., the certified nurse assistant (CNA) informed the registered nurse (RN) that the resident was talking with slight slurring. The nurse assessed the resident, and vitals were obtained: Blood pressure (BP) was 68/42 (normal 120/80), Heart rate (HR) was 94 (normal 60-100), recheck BP was 78/44, HR was 142, Oxygen saturation was 90% (normal 95 to 100%). The resident was placed on oxygen at 3 liters, increased up to 97%. Decreased oxygen to 2 liters and called 911. The Director of Nursing (DON) sat with the resident while waiting for the ambulance. Emergency Medical Services (EMS) arrived and transported the resident to the hospital;-On 06/18/26, at 11:00 P.M., staff contacted the emergency room (ER) for report. The ER nurse explained via phone that the patient was given intravenous (IV) fluids for dehydration. The ER doctor also suggested swapping the tizanidine (short-acting muscle relaxer) order and instead using Robaxin (muscle relaxant for short-term relief) for less sedating effects on the patient;-No documentation of family or responsible party notification. Review of the emergency department note, dated 06/18/26, showed the resident arrived at the ER at 2:50 P.M. and was discharged from ER at 6:27 P.M. During an interview on 07/29/26, at 10:45 A.M., Resident #1 said that he/she went to the hospital for treatment of low blood pressure and not feeling well. The hospital brought him/her back to the facility later that day. He/She does not know if the staff contacted his/her family. During an interview on 07/29/26, at 10:30 A.M., RN A said when a resident has a change in condition or is sent to the hospital, the nurse should contact the family. This information should be documented in the resident's chart. During an interview on 07/29/26, at 10:40 A.M., RN B said the following:-If a resident is sent out to the hospital, he/she would chart the resident's condition;-He/she would notify the physician, the family, the DON, (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and hospice, if applicable and document the notification;-If the resident re-admits, he/she would chart that the resident returned, including contact made with the family, DON, and physician. During an interview on 07/29/26, at 11:05 A.M., Social Services said the following:-Nursing staff should document the reason the resident was transferred to the hospital and notifications (physician, family, and management);-When a resident returns from the hospital, staff should chart how they arrived, such as via ambulance or private vehicle, the time they returned, and the resident's overall appearance;-Staff should notify the family and physician when the resident returns, and document the information in the resident's chart;-He/She is unaware if Resident #1's family was notified of his/her discharge to the hospital or return. During an interview on 07/29/26, at 2:35 P.M., Licensed Practical Nurse (LPN) D said the following:-When a resident is sent to the hospital, nursing staff should make a progress note that includes the resident's condition, notification of DON, physician, family, and hospice, if applicable;-When a resident returns from the hospital, staff should complete an assessment of the resident and notification should be made;-This information should be documented in the resident's chart. During an interview on 07/29/26, at 3:05 P.M., LPN E said the following:-Resident #1 was transported to the emergency room;-He/She does not know if the family was contacted when the resident was transferred to the hospital, or when he/she returned;-All notifications made should be documented in the resident's chart. During an interview on 07/30/26, at 1:50 P.M., LPN C said the following:-He/She re-admitted Resident #1 when he/she returned from the hospital;-He/She does not recall if he/she contacted the family upon the resident's return;-Nursing staff should document notifications (physician, DON, and emergency contact) when a resident returns from the hospital;-An assessment and vital signs should also be documented upon return. During an interview on 07/30/26, at 10:40 A.M., the DON said the following:-Resident #1 was sent by ambulance to the hospital due to elevated heart rate and low blood pressure;-The physician was contacted and a message was left for the family;-The hospital did not call the facility when the resident was discharged from the hospital;-The family should have been notified when the resident returned from the hospital;-All notifications should be documented in the resident's chart. During an interview on 07/30/26, at 1:55 P.M., Administrator said the following:-Nursing staff should document the resident's condition prior to being sent to the hospital;-Notifications, including the physician and responsible party, should be made and documented;-Staff should document when the resident returns from the hospital, along with responsible party notifications. #3050052		