STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265404	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Terrace Living Center	10300 East Truman Rd Independence, MO 64052

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one sampled resident (Resident #1) out of six sampled residents, was free from a significant medication error when on 4/1/26 the resident was administered five milliliters (mL) of Methadone HCL Oral solution (a long acting synthetic opioid used for chronic pain) instead of 0.5 mL that was ordered. The facility census was 48 residents.Review of the facility's policy, Administering Medications, dated April 2019 showed:-The Director of Nursing (DON) supervises and directs all personnel who administer medications.-Medications to be administered in accordance with prescriber's orders. -Medication errors to be documented, reported, and reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to inform process changes and the need for additional staff training.-If a dosage was believed to be inappropriate or excessive for a resident, or a medication identified as having potential adverse consequences for the resident or suspected of being associated with adverse consequences, the person preparing or administering the medication should contact the prescriber, the resident's attending physician or the facility's Medical Director to discuss the concerns.-The individual administering the medication was to check the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. (The five rights of medication administration). Review of the facility's policy, Medications Brought to the Facility by the Resident/Family dated April 2007 showed:-The facility should not ordinarily permit residents and families to bring medications into the facility.-The facility discourages the use of medications brought in from outside and would inform residents and families of that policy.-If a medication was not available or it was determined to be essential to the resident's life to be able to take a medication brought in from outside, the DON with the support of the attending physician and consultant pharmacist should check to ensure:-The contents of each container were labeled in accordance with established policies.-The contents of each container have been verified by a licensed pharmacist. Review of the facility's policy, Specific Medication Administration Procedures, dated 7/1/24 showed staff were to:-Review the 5 rights of medication administration three times.-Prior to removing the medication from the container; check the label against the order on the Medication Administration Record (MAR). 1. Review of Resident #1's admission Referral Packet dated 3/27/26 showed he/she had physician's orders that included Methadone 5 mg/5 mL solution, take 5 mg by G-Tube every 8 hours as needed for pain dated 3/17/26. Review of the resident's face sheet showed: -admitted on [DATE].-Diagnoses of Epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures (a temporary, uncontrolled surge of electrical activity in the brain that causes disturbances in movement, behavior, sensation, or awareness) caused by abnormal electrical activity in the brain), deletions from the autosomes (a genetic disorder which causes a mutation causing a wide range of developmental delays), pneumonitis (inflammation of the lung tissue due to inhalation of food and vomit), sepsis (a life- threatening emergency caused by the body's extreme dysfunctional response to an infection)and dysphagia (difficulty swallowing).-Gastrostomy Status (G-Tube is a surgical procedure where a feeding tube is placed directly into the stomach through the abdominal wall to provide nutrition, fluids, or medications).-Was on Hospice care (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 - Minimal harm or potential for actual harm Residents Affected - Few	(specialized comfort care for individuals with a terminal illness of six months or less to live). Review of the resident's Nurses' Note dated 3/30/26 showed the Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff for care planning) Coordinator had returned to the office to transcribe the resident's orders into the chart from the hospice paperwork received on 3/28/26 with Durable Power of Attorney (DPOA- a person previously identified to make decisions for an individual in the event of inability to make wishes known)/family member stating there was no change in the orders. Review of the resident's Hospice Note, dated 3/30/26, showed: -The resident had physician's orders for Methadone 10 mg/mL concentrate, give 0.5 mL (5 mg) per G-Tube every eight hours, last filled on 3/27/26.-On 3/30/26 the hospice nurse should have collaborated with the facility staff regarding the patient's medications. Review of the resident's Baseline Care Plan dated 3/30/26 showed he/she had:-PURA (Purine Rich Element Binding Protein A) syndrome (a rare genetic disorder that affects neurodevelopment).-Generalized pain.-An end stage disease, with a terminal prognosis (life expectancy less than six months). Review of the resident's admission MDS dated [DATE] showed the resident was non- verbal, unable to provide a Brief Interview for Mental Status (BIMS)- score was 99. Review of the resident's Physician's Order Sheet (POS) dated March 2026 showed the following orders:-Family to supply all medications, dated 3/30/26.-The resident was to receive Methadone HCL Oral solution 5 mg/5mL, give 5 mL by mouth three times a day for pain, dated 3/30/26. Review of the resident's Medication Administration Record (MAR) dated March 2026 showed:-The resident to receive Methadone HCL oral solution 5 mg/5 mL give 5mL by mouth three times a day for pain. -He/She was to be given one bedtime dose on 3/30/26.-The following day (3/31/26) he/she was to be administered three doses (morning, noon, and bedtime).-Facility staff documented that all doses were administered. Review of the resident's POS dated April 2026 showed the following orders:-Family to supply all medications, dated 3/30/26.-The resident was to receive Methadone HCL Oral solution 5 mg/5 mL, give 5 mL by mouth three times a day for pain, dated 3/30/26, and discontinued on 4/1/26.-Showed the corrected medication order entry for Methadone HCL Oral Concentrate 5 mg/0.5 mL. Give 0.5 mL enterally (feeding tube) every 8 hours for pain, dated 4/1/26, and documented to be on hold 4/1/26 to 4/4/26. Review of the resident's MAR dated April 2026 MAR showed:-The resident was to receive Methadone HCL oral solution 5 mg/5 mL give 5 mL by mouth three times a day for pain was given:-The morning dose on 4/1/26 was documented as administered. Review of the resident's Hospice Note, dated 4/1/26 showed: -On 4/1/26 at 1:35 P.M., the DON had called and reported the resident had received a total of 25 mg of Methadone rather than the prescribed dose of 5 mg. -The person (nurse) who had administered the medication saw 5.0 mL instead of 0.5 mL. -This (error) was not discovered until approximately 1:00 P.M. (on 4/1/26).-Per the DON's report the resident was sleeping, respirations were 14 to 16 (per minute), they did not do any additional vital signs because he/she was sleeping.-Upon examination of the bottle of Methadone the concentration was 10 mg/mL with a dosage of 0.5 mL (to be given) every eight hours. -The DON reported the nurse administered Methadone 5 mL instead of 0.5 mL. -The medication was entered incorrectly into the computer system.-The nurse who gave the medication noticed the discrepancy between the computer screen and the bottle but decided to dose based on what the computer said instead of what the bottle said.-The nurse, Licensed Practical Nurse (LPN) A did not perform any safety checks or alert the DON prior to administration. -The DON said the dose was given at 8:00 A.M. and the patient went to sleep at 9:00 A.M. or 9:30 A.M. and had been asleep since then. -The DON was not made aware of anything until 11:30 A.M. (on 4/1/26), more than three hours after the dose was given. -The DON said he/she should have double-checked the computer order. Review of the facility investigation dated 4/1/26 included a picture of the resident's bottle of Methadone (a specific brand-name, cherry-flavored, pre-mixed liquid formulation of methadone, designed to be 10 times more concentrated (10 mg/mL) than traditional pharmacy-compounded methadone solutions (1 mg/mL) showed Methadone Hydrochloride (HCL) 10 mg/mL concentration, last filled 3/17/26, take 0.5 mL (5 mg) by G-Tube every eight hours. Review of the resident's Nurses' Note dated 4/1/26 at 4:30 P.M., (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed by the DON showed he/she called Poison Control and was advised to monitor the resident's vital signs for two to three days due to the half-life of the medication given. During an interview on 4/15/26 at 1:00 P.M., LPN A said:-The resident admitted to the facility on [DATE].-His/Her first day working with the resident was on 4/1/26.-All the resident's medications were to be administered through his/her feeding tube.-The order on the resident's MAR showed to administer Methadone 5 mL/5 mg three times a day (TID) via the resident's feeding tube.-He/She went to administer the resident his/her medication at 7:45 A.M. (4/1/26), on the way to the resident he/she spilled the medication, he/she obtained and gave a replacement dose.-He/She informed the DON that he/she needed help wasting the dose that was spilled in the Mediprosity (electronic narcotic tracking system) system.-About 10:30 A.M., he/she and the DON went to document the spilled amount as a waste. -He/She and the DON then discovered the medication error as the Mediprosity system said to administer 0.5 mL not 5.0 mL that was given. -He/She had looked at the order on the MAR and had not compared what the order on the bottle of Methadone to the order on the MAR. -The DON informed the resident's LPN D a family member of the resident working at the facility of the error. -The DON verified what the correct dose was with the DPOA, which should have been to administer Methadone HCL Oral Concentrate 5 mg/0.5 mL. Give 0.5 mL enterally (feeding tube) every 8 hours for pain-He/She should have compared the order on the MAR to what the order on the medication bottle showed.-In the past hospice has changed orders but used the same bottle with a different amount to have been given. -He/She was aware of the five rights of medication administration and had not followed it. During an interview on 4/15/26 at 3:15 P.M., the DON said:-On 4/1/26 at around 11:00 A.M., LPN A said he/she had spilled the resident's Methadone and needed to waste it in the Mediprosity system.-The nurse said he/she needed to waste 5 mL. -LPN A should have given 0.5 mL but gave 5.0 mL of the Methadone.-They recorded the waste as the LPN had spilled the medication and needed a second dose which he/she had given to the resident. -He/She went to assess the resident, who was sitting in his/her chair resting with his/her eyes closed.-Hospice had documented the resident was terminal and had been receiving hospice care at home. -The medications for the resident had come from home supplied by LPN D, who was a nurse at the facility. -The physician had written an order stating the family was to supply the medications.-The facility pharmacy should have verified the medications LPN D had brought in.-He/She had put the order in Mediprosity. -The order on the bottle of Methadone from home said to give 0.5 mL TID.-The LPN D had entered the order into the MAR system which said to give 5 mL not 0.5 mL that was on the bottle. -Usually, the physician was notified of the ordered medications and would sign off on them.-The resident's original orders had come from hospice. -He/She had not had anyone bring in their own medications upon admission.-The medications were verified by the hospice pharmacy before they went to the resident's home.-He/She did not know anything about hospice nurse coming into the facility to verify the resident's medications. During an interview on 4/15/26 at 1:50 P.M., the Administrator said:-He/She had started a QAPI about the medication error on 4/1/26. The root cause was the facility received an order from hospice that showed to give 5 mL TID.-On the bottle of Methadone that the family had brought in from home provided by hospice showed to give 0.5 mL. -The resident had been given the correct dose once on 3/30/26 and three times on 3/31/26.-The error happened on 4/1/26 with the morning dose. -The coroner came to the facility and took the bottle of Methadone with him/her after the resident passed. -The facility had a picture of the bottle of Methadone the coroner took with him/her.-The picture of the resident's bottle of Methadone showed:--Take 0.5 mL (5 mg) by G Tube every (8 hours) Methadone HCL 10 MG/mL. (0.5 mL equals 5 mg, 5 mL equals 50 mg). During an interview on 4/17/26 at 9:00 A.M., LPN B said:-He/She worked with the resident on 3/31/26.-He/She took the medication from the nurses' cart and followed the directions on the bottle.-He/She gave the morning and noon dose of medication on 3/31/26.-He/She knows about the five rights of medication administration and did not follow them.-He/She should have compared the bottle of Methadone to the order on the computer and did not do that or he/she may (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have caught the discrepancy if he/she had.-He/She gave the medication to the LPN D to give to the resident on 3/31/26 and signed off on it as given.-He/She should not have given the medication to LPN D as he/she did not see the resident take the medication, but he/she was very busy.-Hospice came in to see the resident. During an interview on 4/17/26 at 9:30 A.M., LPN C said:-He/She had worked with the resident a couple of weeks ago.-He/She administered the dose that was on the bottle, but did not look at the MAR.-If he/she had compared what was on the bottle to what the MAR said he/she may have noticed the discrepancy. -He/She knows about the five rights of medication administration and had not followed them.-He/She worked nights and administered the Methadone on 3/30/26 and 3/31/26 the night dose.-The resident was up until 3:00 A.M.-The medications should have been checked by the facility pharmacy when they were brought into the facility. During an interview on 4/17/26 at 9:30 A.M., the Hospice Medical Director said:-The dose was to have been 0.5 mL. The prescription was 10 mg/mL so if the resident received 5.0 mL then the resident received 50 mg.-They do not send medications from the home to a facility.-The hospice nurse went to the facility to do the medication reconciliation and facility staff declined to allow the hospice nurse to do the review. During an interview on 4/17/26 at 10:10 A.M., the facility Pharmacist said:-Medications were verified by the hospice pharmacist before they were sent to the resident's home.-He/She would not have accepted the medications if he/she was the facility especially since there was an opened bottle (the Methadone) as you would not be able to verify the contents.-Usually, hospice would send them the prescriptions before the resident went to the facility, and they would fill the prescription at no cost to family then it would be sent to the facility.-The wrong amount was entered into the computer.-The nursing home staff should have verified the amount on the bottle of Methadone to the prescription on the computer. -They deliver to the facility six days a week. During an interview on 4/21/26 at 10:00 A.M., Hospice Registered Nurse (RN) A said:-On 3/30/26 the resident was admitted to the facility with a medication list and the medications which included a bottle of Methadone.-He/She was told the medication had already been verified and entered into the computer system, so it was done.-If he/she had verified the medications he/she would have caught discrepancy in the order and on the opened bottle of Methadone.-The bottle of Methadone was 10 mg/1 mL, 0.5 mL was to have been given three times a day.-50 mg was given.-New medications should have been ordered from the pharmacy and verified by the nurse who accepted the medications from the pharmacy. 2972671