STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265433	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln County Nursing & Rehab	1145 East Cherry Street Troy, MO 63379

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(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 - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview, and record review, the facility failed to maintain a safe and effective medication system when morphine (narcotic with a high potential for abuse) prescribed for Resident #1 and Resident #2, had been tampered with, a card of oxycodone (a potent semisynthetic opioid agonist prescription medication used to treat severe pain) was missing from the facility emergency medication kit, when staff failed to document the narcotic count was completed before and after their shift, and when an Ozempic (prescription injectable medication used to treat type 2 diabetes: and for weight loss) insulin pen was found to be tampered with and the contents replaced by another type of insulin for Resident #4. The facility census was 71. Review of the undated facility policy for Storage of Medication showed the following: -All medications for residents must be stored at or near the nurse's station in a locked cabinet, a locked medicine room, or one or more locked mobile medication carts; -Biologicals or medications requiring refrigeration must be kept in a separate, securely fastened refrigerator at or near the nurses' station; or in a refrigerator within a locked medication room. -All controlled substances must be stored under double lock and key. Review of the undated facility policy for Scheduled II-V Medications (Schedule II medications are typically prescribed to treat severe pain, anxiety and insomnia. Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. Schedule V medications are drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics. Schedule V drugs are generally used for antidiarrheal, antitussive, and analgesic purposes) showed: -Schedule II-V medications may be kept in medication cart lock box, refrigerator, boxes, or double lock box maintained in medication rooms; -Scheduled medications will have disposition records that are in a binder on medication cart or area instructed by the Director of Nursing (DON); (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All Schedule II, III, IV and V medications must be counted (comparing number of pills to disposition record) at every change of shift by two Certified Medication Technicians (CMT), or one CMA and one licensed nursing staff. Both personnel must sign verification of correct count for Schedule II, III, IV and V medications. The facility did not provide a requested policy for utilization of the Stat Safe (emergency medication kit). 1. Review of Resident #1's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD - a lung disease that results from damage to the lungs or airways, which can lead to inflammation and other issues that make breathing difficult), shortness of breath, chronic cough, and kidney disease. Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by staff, dated 8/31/24 showed: -The resident was able to make self understood and able to understand others; -Alert and oriented and able to make appropriate decisions; -Independent with Activities of Daily Living (ADLs); -Has pain at a level 6 (zero being no pain and 10 being unbearable pain) and was taking opioid medication. Review of the resident's Physician Order Sheet (POS) for September 2024 showed an order for morphine concentrate (opioid medication for relief of moderate to severe acute and chronic pain), Schedule II medication solution; 100 milligrams (mg) per 5 milliliter (ml) (20 mg/ml); amt: 0.25 ml; orally for pain every 4 hours as needed with an order date of 2/28/24. Review of the resident's Medication Administration Record (MAR) for September 2024 showed morphine concentrate 0.25 mg administered on 9/10/24 at 5:37 P.M. 2. Review of Resident #2's face sheet showed the following: -admitted to the facility on [DATE]; -Diagnoses of acute respiratory failure and pain. Review of the resident's quarterly MDS dated [DATE] showed the following: -Sometimes understands others and sometimes able to make self understood; -Unable to make decisions; -Dependent upon staff for ADLs'; -Has occasional pain at a level 4 and receives pain medication as needed. (continued on next page)

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(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 - Some	Review of the resident's POS for September 2024 showed and order for morphine concentrate - Schedule II solution; 100 mg/5 ml (20 mg/ml); amt: 0.25 ml; orally with special instructions to give 0.25 ml sublingual (under the tongue) every 4 hours as needed. Review of the resident's MAR for September 2024 showed morphine concentrate 0.25 mg administered on 9/10/24 at 10:20 A.M. and 7:15 P.M. During an interview on 10/15/24 at 12:40 P.M. LPN A said the following: -Resident #1 requested morphine for pain on 9/13/24, when he/she opened the morphine bottle to administer the medication, the morphine had a funny smell, like mint. The morphine he/she had given in the past, had no particular smell. He/She notified the Assistant Director of Nursing (ADON) and upon checking the morphine for Resident #2, noted the resident's morphine had a bubblegum smell. Both were removed and destroyed and the pharmacy replaced the medication; -He/she had counted medication with the off going nurse at 6:00 A.M. on 9/13/24, but had not smelled the medication (morphine). During an interview on 10/4/24 the Director of Nursing (DON) said the following: -It was reported on 9/13/24 by Licensed Practical Nurse (LPN) A that the morphine concentrate for Resident #1 did not smell right. The morphine smelled like mint which was unusual. Upon checking the morphine in the medication cart, the morphine for Resident #2 had a bubblegum smell. Both of the morphine bottles were removed from the medication cart and destroyed. The facility contacted the pharmacy and had the medication replaced. 3. Observation on 10/4/24 at 4:30 P.M. of the Certified Medication Technician (CMT) medication cart showed the following: -A controlled substance shift change log book with individual sheets for the staff to sign by the on coming staff and off going staff that the controlled substance count and number of medication cards was correct; -A notation at the bottom of the sheet signing signified all doses are recorded on the MAR, count sheets match inventory on hand and package log matches actual package count; -No off going signature for 10/1/24 at 7:00 A.M.; -No on coming signature or off going signature for 10/1/24 at 11:00 P.M.; -No off going signature for 10/2/24 at 7:00 A.M. and no on coming signature for 3:00 P.M ; -No off going signature for 10/3/24 or on coming signature for 3:00 P.M. and no count or on coming or off going signature for 11:00 P.M. -No off going signature for 10/4/24 at 7:00 A.M. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Several medication cards for lorazepam (used to relieve anxiety and is a controlled substance) and alpramazole (Alprazolam is frequently prescribed to manage panic and anxiety disorders and is a controlled substance) During an interview on 10/4/24 at 4:30 P.M. the DON and Assistant Director of Nurses (ADON) said the CMTs pass lorazepam (a schedule IV controlled medication to relieve anxiety) and was not a narcotic that needed to be monitored. The facility does not audit the CMT medication carts for any tampering or missing medications. During an interview on 10/4/24 at 4:35 P.M. CMT B said the following: -Two CMT's or a CMT and a nurse will count the number of cards of narcotics in the medication cart and then count the number of pills in each card. They will sign the shift change log indicating that the count was right; -He/She did not count when he/she came on the shift as the day shift CMT had already left and there wasn't a nurse available to count with him/her. During an interview on 10/8/24 at 12:20 P.M. CMT C said the following: -The on coming CMT should count the cards of narcotics with the off going shift CMT or nurse and then the actual pills in each card of the medication; -This should be done at every shift change. 4. Observation on 10/8/24 at 2:00 P.M. of a nurse medication cart for the 100 and 400 halls and the refrigerator in the nurses' medication room showed the following: -A controlled substance shift change log book with individual sheets for the staff to sign by the on coming staff and off going staff that the controlled substance count and number of medication cards were correct; -A notation at the bottom of the sheet signing signified all doses are recorded on the MAR, count sheets match inventory on hand and package log matches actual package count; -No off going signature for 10/1/24 at 7:00 A.M., no count of medication noted for 10/1/24 or an on coming signature for 7:00 A.M.; -No count of medication noted on 10/2/24 or on coming or off going signatures; -No off going signature for 10/3/24 at 7:00 A.M. -No off going signature for 10/6/24 at 11:00 P.M.; -Several bottles of morphine, cards of oxycodone and liquid Ativan (controlled medication) that were kept in the refrigerator in the nurses' medication room (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/8/24 at 2:15 P.M. of the Med Nurse cart for the 200, 500 and 600 halls and the refrigerator in the nurses' medication room showed the following: -A controlled substance shift change log book with individual sheets for the staff to sign by the on coming staff and off going staff that the controlled substance count and number of medication cards were correct; -A notation at the bottom of the sheet signing signified all doses are recorded on the MAR, count sheets match inventory on hand and package log matches actual package count; -No off going signature on 10/1/24 at 7:00 A.M. or no on coming signature on 10/1/24 at 11:00 P.M. -No off going signature on 10/2/24 at 7:00 A.M. or on coming signature for 11:00 P.M.; -No off going signature for 10/2/24 at 7:00 A.M. or 3:00 P.M. or on coming signature for 3:00 P.M.; -No on coming signature for 10/4/24 at 7:00 A.m. or 3:00 P.M. or no count of medication noted at 3:00 P.M. -Several bottles of morphine, cards of oxycodone and liquid Ativan that were kept in the refrigerator in the nurses' medication room During an interview on 10/8/24 at 3:05 P.M. the DON said she would expect the CMT's and the nurses to count the number of cards that are in the locked narcotic box and the number of pills in each card and the number of liquid bottles and the amount in each bottle when they come on the shift and when they go off shift together and document on the controlled substance shift change log. During an interview on 10/8/24 at 3:10 P.M. the Administrator said the following: -She would expect staff to follow the policy for medication administration and narcotics; -She would expect staff to count the narcotics at the beginning of their shift with the on coming staff and the off going staff; -She would expect all medications to be documented and accounted for. 5. Review of Resident #4's face sheet showed: -admitted to the facility on [DATE]; -Diagnoses of diabetes. Review of the POS for September 2024 showed the following: -Ozempic (semaglutide) pen injector; 2 mg/dose (8 mg/3 ml); amt: 2 mg; subcutaneous with special instructions to inject 2 mg once a day on Wednesday; -Order date of 7/25/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/4/24 at 1:30 P.M. the Administrator said the following: -Several weeks ago, a resident's morphine (another resident in addition to Resident #1 and #2), had been tampered with. The DON and ADON had been doing audits of the narcotics three times a week; -On 9/13/24, the facility had two bottles of morphine concentrate that appeared to have been tampered with. The smell of the medication in both of the bottles was not correct. The pharmacy indicated that the morphine concentrate should smell like raspberry. -On 9/25/24, the consultant pharmacist discovered that a card of oxycodone (a Schedule II narcotic used to treat severe pain, for example after an operation or a serious injury, or pain from cancer) was missing from the facility Stat Safe (emergency drug kit). Only the pharmacist had been checking the Stat Safe monthly on their routine visits to the facility; -A couple of weeks ago, a pen of Ozempic (a prescription injectable medication used to treat Type II diabetes in adults), was found to tampered with and replaced with a different type of insulin (replaced with a pen that was not an Ozempic pen). No one had been checking the Ozempic insulin pens to see if the medication had been tampered with. During an interview on 10/8/24 at 3:05 P.M. the DON said she would expect the CMT's and the nurses to count the -When the pharmacist found the missing oxycodone, they discovered that a nurse did not have to have a witness of when they took a medication from the Stat Safe. -She would expect the staff to have to nurses when getting medication out of the Staff Safe, and have two staff members count the narcotic medication at the beginning of each shift and sign that the count is correct. MO242133 MO242628

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 34003 Based on observation, interview, and record review, the facility failed to provide food items at a safe and appetizing temperature. The facility census was 71. Review of the facility policy for Food Temperatures dated 5/2015 showed: -The Dietary Manager or designee is responsible for seeing that all food is the proper serving temperature(s) before trays are assembled; -Keep the temperature of hot foods no less than 140 degrees Fahrenheit (F) during meal service; -Hot foods should be at least 120 degrees F when served to the resident; -Keep the temperature of potentially hazardous cold foods no greater than 40 degrees F. Prepare cold items a day in advance when possible. Please items in freezer 45 minutes before service and use ice baths when needed; -A test meal should be sent with the hall trays when there are food temperature complaints until the temperatures are at the appropriate levels. Record on Temperature Record of Test Trays form; -Do not cook or heat food in the steam able because it fosters bacteriological growth and is detrimental to product quality. Heat food to the proper temperature by direct heat (using a stove, over, steamer, etc.) and then transfer food to the preheated steam table no more than 30 minutes before meal service; -Place cold items such as ham salad and egg salad in the steam table over an ice bath with the well of the steam table turned off. -Potentially hazardous foods are not held at room temperature during meal service. 1. During an interview on 10/4/24 at 2:05 P.M. Resident #8 and Resident #9 said the following: -They get meals in their rooms and the food was cold and often late; -Staff usually brought their breakfast around 8:30 A.M. or 9:00 A.M., lunch around 1:00 P.M. to 1:30 P.M., and supper at 6:00 P.M. to 6:30 P.M. During an interview on 10/4/24 at 2:30 P.M. Resident #10 said he/she eats meals in his/her room. When staff serve the meals the food was almost always cold. During an interview on 10/8/24 at 11:30 A.M. Resident #11 said he/she eats meals in his/her room. When staff serve the meals the food was never hot. Observation on 10/8/24 at 12:05 P.M. showed the following: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff served the noon meal to 22 residents in the main dining room with four staff members present; -The meal consisted of vegetable soup, a cold ham sandwich, chips, sliced melon, milk, tea, fruit punch or coffee; -Glasses of milk, tea and fruit punch sat on a cart. None of the items were on ice; -Staff completed meal service to the main dining room at 1:00 P.M.; -At 1:10 P.M. the hall cart for the 400 hall left the kitchen for food service; -At 1:15 P.M. the hall cart for the 500 hall left the kitchen for food service; -At 1:15 P.M. dietary staff prepared four trays for the 100 hall cart. The trays sat on the counter for five minutes as there was no staff in the dining room to place the drinks on the trays and load the trays onto the cart. At 1:22 P.M. a staff member came into the dining room and placed the trays on the 100 hall cart and placed glasses of milk, tea and fruit punch on the trays; -The cart for the 100 hall left the dining room for service with the last tray being served to a resident on the 100 hall at 1:34 P.M. Observation at 1:35 P.M. of food temperatures of the test tray showed the following: -Soup was 118 degrees F; -Milk was 62 degrees F; -Tea was 60 degrees F; -Ham on the sandwich was 52 degrees F. During an interview on 10/8/24 at 1:40 P.M. the Dietary Manager said the following: -She had taken the temperature of the soup before meal service and it was 165 degrees F; -Hot food should be served at 120 degrees F and cold food at 42 degrees or below; -The drinks should have been placed on ice; -She was not sure how to keep the soup hot for serving. During an interview on 10/8/24 at 2:05 P.M. the Administrator said the following: -Beverages should be kept on ice until served; -She would expect the meal to be served in a timely manner and the foods to be at the proper temperatures. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MO242628