STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265447	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McDonald County Living Center	1000 Patterson Street Anderson, MO 64831

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 0554 Level of Harm - Actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43193 Based on interview and record review, the facility failed to ensure resisdents were appropriately asssesed to have medicaiton at bedside prior to providing bedside medications to residents when staff returned the resident's home medications to the resident prior to the resident exiting the facility for one resident (Resident #1), out of six sampled residents. The resident self-administered two medications and was found unresponsive. The facility census was 58. On 06/24/24, the Director of Nursing (DON) was notified of the Past Non-Compliance that occurred on 06/24/24. The DON notified the physician and the Administrator. The DON completed in-service education with all licensed nurses and certified medication technicians (CMT) regarding dispensing and releasing medications to residents. The noncompliance was corrected on 06/25/24. Review of the facility's policy titled Medication, Administration Guidelines, undated, showed the following: -It is the purpose of this facility that residents receive their medications on a timely basis and in accordance with established policies. Drug administration shall be defined as an act in which an authorized person, in accordance with all laws and regulations governing such acts, gives a single dose of a prescribed drug or biological to a resident. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the information; -Self-administration of drugs is permitted with the written order of the attending physician. Review of the facility's policy titled Medications, Release of, undated, showed the following: -Drugs which have been dispensed for individual resident use and are labeled in conformance with state and federal law may be furnished to the resident upon their discharge, provided that: the physician gives orders to discharge and to send medications with resident, including controlled substances; when resident leaves AMA (against medical advice) and the physician orders medications to be sent with resident; or the resident is discharged to another health care facility; -The staff will be responsible for documenting the medications provided upon discharge in the resident's medical record; (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 0554 Level of Harm - Actual harm Residents Affected - Few	-Medications and special instructions for their administration are outlined in the resident's discharge plan when the resident is discharged to home; -When medications have been released to the resident, the staff must record the data in the resident's medical record, using the release of medication form. Review of the facility's policy titled Medications, Self-Administration, Self Storage, Leave at Bedside, undated, showed the following: -The resident has a right to self-administer medication unless the interdisciplinary team has determined that this practice is unsafe for an individual resident; -If a resident expresses a desire to self-administer medication, the interdisciplinary team must assess the resident's cognitive, physical and visual ability to carry out this responsibility. The mental status and any psychiatric diagnoses must be taken into account. The Evaluation Assessment to Self-Administer Medications will be used for this purpose; -When the resident self-administers medication, the resident will be re-assessed on an ongoing basis for continued safety of this practice. The evaluation assessment will be completed annually or with significant change by nursing and reviewed by the interdisciplinary team to determine if the resident is still capable of self-administer medications; -For self-administration of prescription medications kept at the bedside: the resident will be assessed as outline in steps 1 and 2; a physician's order will be obtained for each medication to be kept at the bedside; the resident will receive a set amount of medication for a set number of days; the medications will be listed on the Medication Administration Record (MAR) and show they are self-administered/kept at bedside; the resident care plan will instruct staff where medication is to be stored and who will document administration of medication; the nurse will interview the resident periodically and assess the number of medications remaining. If at any time there is a question as to the continued safety of this practice, the nurse will initiate the reassessment process; and the nurse will document findings during the resident interview. They will also document required monthly education given to the resident regarding any medication kept at the bedside; -The physician's order sheet (POS) will reflect the current status of the resident's self-administering medications. The plan of care and the monthly summary will reflect the status of self-administration and the cognitive, visual, and physical ability of the resident to perform this task. The mental status and any psychiatric diagnoses must be reviewed. This must also address the safety of storing bedside medications and continued monthly education; -Type II medications, both over-the-counter and prescription, must be properly labeled and stored in a locked area. If the resident does not provide a locked box, the facility must provide a locked area for the medications. 1. Review of Resident #1's face sheet (a document that gives a patient's information at a quick glance) showed the following: -The resident admitted on [DATE] and discharged on [DATE]; (continued on next page)

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F 0554 Level of Harm - Actual harm Residents Affected - Few	-The resident was his/her own responsible party; -Diagnoses included urinary tract infection (an infection in any part of the urinary system), insomnia (difficulty sleeping), depression and anxiety. Review of the resident's discharge Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 06/24/24, showed the following: -The resident's memory was okay, cognitive skills for daily decision making was independent, and had an acute onset of altered level of consciousness; -The resident had verbal behavioral symptoms directed towards others and rejected cares; -The resident required set-up assistance from staff for eating and oral hygiene, maximum assistance from staff for upper and lower body dressing and was dependent on staff for toilet hygiene and personal hygiene; -The resident was dependent on staff to roll left and right in bed. Review of the resident's care plan, dated 06/24/24, showed the following: -Disease management included high blood pressure, post-surgical care, respiratory, and pain. Interventions included monitor medications, provide safe environment, monitor condition and report changes to the Director of Nursing (DON) or physician as applicable, and provide comfort and care; -Maintain health and safety while performing activities of daily living (ADLs - dressing, bathing, eating, grooming, etc.) as independently as possible. Assist with ADL care as needed to promote health, hygiene, and safety. Encourage self-care participation. Allow the resident extra time to complete tasks on his or her own. Review of the resident's Physician's Order Sheet (POS), dated 06/2024, showed the following: -An order, dated 06/23/24, for Lunesta (a medication used to treat insomnia) 3 milligram (mg) tablet, one tablet by mouth at bedtime, 7:00 P.M. to 10:00 P.M.; -An order, dated 06/23/24, for hydrocodone-acetaminophen schedule II tablet (a controlled medication to treat pain), 10-325 mg, one tablet by mouth every 4 hours as needed for moderate pain. (There was no order to allow the resident to keep his/her medications at bedside.) Review of the resident's medical record showed staff did not document an assessment to show the resident was safe to have medications at bedside. Review of the resident's MAR, dated 06/2024, showed the following: -Staff did not administer the resident's as needed hydrocodone-acetaminophen 10-325 mg on 06/23/24 or 06/24/24; (continued on next page)

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F 0554 Level of Harm - Actual harm Residents Affected - Few	-Staff administered the resident's Lunesta 3 mg on 06/23/24 at bed time. Review of the resident's progress notes showed the following: -On 06/24/24, at 1:09 A.M., the resident complained of constipation. The resident passed a medium hard stool. He/she complained of not having his/her medications with her. He/she wanted to go home. He/she was encouraged to remain in the facility until morning and explained the need for therapy for strengthening. Staff changed the dressing on the resident's right hip with no redness or drainage noted. Twenty-two staples present in the resident's right thigh and hip. The suture line was well approximated. The resident's speech was clear and he/she was able to verbalize his/her needs. He/she was turned and repositioned with two staff. The resident had been incontinent of bowel and bladder; -On 06/24/24, at 3:27 A.M., the resident called 911 to get a ride to leave the facility. The 911 dispatcher called the facility to inquire if the resident was here. It was verified that he/she was here and they asked this nurse to check on him/her. The resident was in his/her bed, talking on the phone to the 911 operator. The resident stated I'm leaving here. I don't want to be here. The resident was asked where he/she wanted to go and he/she stated Home. My neighbor can help me. The resident initialed the AMA paper. He/she called 911 several times from his/her cell phone. The police department called to speak with the resident. He/she was informed to stop calling 911 and someone would talk to him/her after they finished with their calls. The physician, Administrator, and DON were notified. The resident was very fidgety, tolling his/her eyes, with a lot of mouth and head movement. He/she said he/she had a lot of anxiety. He/she refused to allow staff to change his/her brief. He/she laid in his/her bed, holding his/her phone and looked through his/her bags. The resident's family member returned the nurse's call. The family member was informed of the situation and the family member stated they were at work and unable to leave at this time. The family member said good luck; -On 06/24/24, at 5:01 A.M., the resident laid in his/her bed. He/she called out on occasion and complained of stomach pain. He/she stated they did ultra sounds and couldn't find anything in the hospital. He/she asked if the police were here yet to take him/her home. He/she was assured that staff would bring the police to him/her when they arrived. No further phone calls to 911; -On 06/24/24, at 9:10 A.M., this writer was in the resident's room at 6:30 A.M. for assessment on the resident due to his/her being new to the facility and demanding to leave AMA on previous shift. The resident would not wake to verbal or external stimuli except to open eyes momentarily. The resident was still non-responsive to verbal stimuli and was reactive to external stimuli as before. The DON was in the facility at this time and he/she was notified of findings; -On 06/24/24, at 10:46 A.M., a registered nurse (RN) went in to assess the resident at 8:00 A.M. The resident was very lethargic and only responsive to painful stimuli. The resident was unable to follow commands or open eyes. The resident's vitals were stable. RN called the physician and informed him of the situation. The physician wanted Narcan (medication used to treat narcotic overdose in an emergency situation) given and called back with update. Narcan given at 8:15 A.M., and the resident was still not very responsive. The physician was called back and the physician ordered to send out to the hospital. Staff called 911 and informed of the resident's situation. The resident was sent to the hospital. The RN attempted to call the resident's family member, but was unable to leave a voicemail; (continued on next page)

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F 0554 Level of Harm - Actual harm Residents Affected - Few	-On 06/24/24, at 12:50 P.M., the Social Services Designee (SSD) spoke with the hospital and let them know that the resident had signed AMA paper before he/she left in the ambulance, so the resident would not be coming back to the facility. During an interview on 08/08/24, at 11:59 A.M., the DON said the following: -The resident came to the facility with home medications from the hospital; -Staff took the medications, counted them, and locked them up; -As the night went on, the resident wanted to leave the facility because staff locked her medications up; -The resident called 911 and wanted to leave AMA; -The police officer told the resident to stop calling 911 and he/she would come to see the resident later; -The nurse gave the resident his/her medications back when the resident signed the AMA form at 3:30 A.M. on 06/24/24; -At 8:00 A.M., staff had a hard time arousing the resident; -He/she assessed the resident and noticed the resident had his/her Lunesta and hydrocodone at his/her bedside; -The resident took one Lunesta and one hydrocodone out of his/her medications, but the DON did not know when the resident took the medications; -The DON called the physician and the physician ordered Narcan; -After the resident received the Narcan, he/she started to arouse more, but not enough and the physician sent the resident out to the hospital to be evaluated; -The resident received one Lunesta from the facility's stock at bed time and then sometime after 3:30 A.M. took one of his/her own; -Staff gave the resident's medications to the EMT; -He/she knew what the resident took out of the home medications because staff counted them when the resident arrived and then again after the resident was found unresponsive; -The nurse should not have given the resident the medications when the resident signed the AMA form, but when the resident was on the way out of the facility; -The nurse thought the resident was leaving soon and gave the resident his/her medications; (continued on next page)

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F 0554 Level of Harm - Actual harm Residents Affected - Few	-When the nurse assessed the resident at 6:30 A.M., the nurse thought the resident was sleeping good because the resident's vital signs were good; -When the resident was later assessed when he/she was less responsive, the resident's vital signs were still within normal limits. During an interview on 08/08/24, at 1:18 P.M., the Administrator said the following: -The resident admitted and had medications with him/her; -Staff took the medications and placed them in the medication storage room; -The resident called 911 during the night and the charge nurse notified the Administrator; -He/she told the nurse where to find the AMA paperwork and the nurse had the resident sign the paperwork; -When he/she arrived the next day, the DON notified him/her the resident received Narcan; -The charge nurse said when the resident signed the AMA paper, he/she demanded his/her medication back because the resident had a ride coming any minute; -When the charge nurse realized the resident's ride had not arrived, he/she should have taken the medications back; -The charge nurse should not have given the resident his/her medications until the resident was going out of the door; -He/she did not know if the resident had an order to keep medications at bedside; -The resident would not have an order to keep narcotics at bedside. During interviews on 08/08/24, at 10:50 A.M. and 12:44 P.M., Licensed Practical Nurse (LPN) B said the following: -If a resident came to the facility with their own medication, he/she took the medication to the nurses' desk, counted the medication, and kept the medication locked up; -He/she did not return the medication to the resident or the resident's family when the resident left the facility; -Staff should not return home medications to a resident after the resident signed an AMA paper; -Staff should not leave medications at the resident's bedside because they could be a risk to the resident or other residents in the facility. During interviews on 08/08/24, at 10:57 A.M. and 12:47 P.M., LPN C said the following: (continued on next page)

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F 0554 Level of Harm - Actual harm Residents Affected - Few	-Staff should not leave medications in a resident's room; -If he/she saw medications left in a room, he/she removed the medication, found out who left the medications and notified the DON; -If certified nursing assistants (CNA) found medications in a resident's personal belongings, they notifed the charge nurse; -The charge nurse secured the medication and assessed the resident to ensure the resident had not taken any of the medication; -Residents were not allowed to keep medications in their room; -If a resident arrived with their own medication, the charge nurse took the medication and inventoried the medication; -The charge nurse sent the medication home with a family member or if the resident did not have a family member to take the medication home, the charge nurse secured the medications in the medication storage room; -When a resident discharged from the facility, he/she gave the resident their medication as they went out of the door after educating the resident on their medications; -Medications should not be kept at a resident's bedside because the resident could take the medications and the charge nurse would not know the combination of the medications the resident took. During an interview on 08/08/24, at 11:53 A.M., the SSD said residents could only keep over the counter medication at their bedside with a physicians order. During an interview on 08/08/24, at 1:18 P.M., the Administrator said the following: -If a resident arrived to the facility with their home medications, staff took the medications to the pharmacy to verify the medications; -If the resident arrived after hours, staff locked the medications up in the medication storage room until they could take the medications to the pharmacy; -If a resident was skilled, the medications were sent home with a family member or kept in the medication storage room until the resident discharged ; -Residents could not keep medication in their room without a physician's order. MO00238167