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	07/30/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide pharmaceutical services that ensured administration of all drugs to meet the needs of each resident when staff failed to have multiple medications available for administration for one resident (Resident #3) and failed to follow-up with the physician and pharmacy regarding the missed doses. The facility census was 56. Review of the facility's policy titled, Medication, Administration Guidelines, undated, showed the following: -It is the purpose of the facility that residents receive their medications on a timely basis and in accordance with established policies; -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 order, giving the individual dose to the proper resident, and promptly recording the information;-The same person preparing the doses for administration must administer the medications;-The person administering the drugs must chart the medications immediately following the administration. The date, time administered, dosage, etc. must be entered in the medical record and signed by the person entering the data. 1. Review of Resident #3's face sheet (a document that gives a resident's information at a quick glance) showed the following:-readmission date of 06/10/25; -Diagnoses included surgery genitourinary system - resection of a bladder tumor, urinary tract infection with bacteremia hematuria (blood present in the urine), urine retention, and benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland that can cause urinary problems), and depression. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/14/25, showed the following: -Cognition intact;-Required supervision for transfers. Review of the resident's care plan, updated 06/16/25, showed the following: -The resident required an indwelling urinary catheter (a thin, flexible tube used to drain and collect urine from the bladder) due to bladder tumor and prostate enlargement;-The resident was at risk of adverse consequences due to receiving antidepressant medication for treatment of depression. Review of the resident's June 2025 Physician Order Sheet (POS) showed the following:-An order, dated 05/16/25, for duloxetine capsule, delayed release (used to treat depression), 60 milligram (mg) capsule once per day;-An order, dated 05/16/25, for (used to treat benign prostatic hyperplasia), one 5 mg tablet once a day; -An order, dated 05/16/25, for mirabegron (used for overactive bladder), 50 mg tablet extended release 24-hour, one tablet daily; -An order, dated 06/10/25, for saccharomyces boulardii (probiotic), one 250 mg capsule twice a day; -An order, dated 05/16/25, for solifenacin (used for overactive bladder), one 10 mg tablet once a day. Review of the resident's June 2025 Medication Administration Record (MAR) showed the following:-An order, dated 05/16/25, for duloxetine capsule, delayed release, 60 mg capsule once per day. Staff did not administer the medication on 06/11/25, 06/12/25, and 06/13/25 due to drug item unavailable;-An order, dated 05/16/25, for Finasteride, administer one 5 mg tablet once a day. Staff did not administer the medication on 06/11/25, 06/12/25, 06/13/25, and 06/15/25 due to drug item unavailable;-An order, dated 05/16/25, for mirabegron, 50 mg tablet extended release 24 hour, one tablet daily. Staff did not administer the medication on 06/11/25, 06/12/25, 06/13/25, and 06/14/25 due to drug item unavailable;-An order, dated 06/10/25, for saccharomyces boulardii , one 250 mg capsule twice a day. Staff did not administer the medication on 06/10/25, 06/11/25, 06/12/25, 06/13/25, 06/14/25, and morning of 06/15/25 due to drug/item unavailable awaiting arrival from the pharmacy.-An order, dated 05/16/25, for solifenacin, one 10 mg tablet once a day. Staff did not administer the medication on 06/11/25, 06/12/25, 06/13/25, and 06/14/25 due to drug item unavailable. Review of the resident's nurses' notes, dated 06/11/25 through 06/14/15, showed staff did not documentation contacting the pharmacy or the physician regarding medications not being administered as ordered.During an interview on 07/24/25, at 3:08 P.M., Certified Medication Tech (CMT) B said the following:-If a resident does not have medication in the cart, then staff should check the stat safe, administer the medication, and document that he/she got it from stat safe;-There is a button on the electronic medication record (EMAR) to reorder medication and that should be clicked if they are running out or it is not available;-He/she was not sure why the resident did not have some of his medication initially upon readmit . Staff should have reached out to the pharmacy and the physician;-Residents should get medication as ordered. During an interview on 07/24/25, at 1: 53 P.M., Licensed Practical Nurse (LPN) A said the following:-He/she was not sure why the resident's medication was not administered as ordered. Resident medications should be administered per the physician's order;-If a medication is not available, staff should contact the pharmacy to see why it is not there and then check the stat safe to see if they can get medication from there. If they are unable to get it from the

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure all residents were free from significant medication errors when staff administered one resident's (Resident #2) insulin to another resident (Resident #1) who did not have orders for insulin and no diagnosis of diabetes. The facility census 56. On 06/25/25, during morning medication pass, Licensed Practical Nurse (LPN A) discovered the medication. The LPN notified the Administrator, Director of Nursing (DON), physician, and family of the medication error. The LPN completed monitoring until the resident left for the hospital. The DON completed an investigation and in-service of all staff on 06/25/25. The facility corrected the non-compliance by 06/26/25. Review of the facility policy titled, Medication, Administration Guidelines, undated, showed the following:-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 order, giving the individual dose to the proper resident, and promptly recording the information;-If there is doubt as to the correct identification of a resident, medication may not be administration to that resident until positive identification has been made. Review of the facility policy titled, Medications, Errors and Drug Reactions, undated, showed the following:-The purpose is to safeguard the resident and provide emergency care as necessary;-Report all medication error and adverse reactions immediately to the attending physician, Director of Nursing (DON) and Administrator;-Document and following the attending physician orders;-Complete resident assessment.1. Review of Resident #2's face sheet a document that gives a resident's information at a quick glance) showed the following:-admission date of 05/04/25;-Diagnoses included type two diabetes mellitus with diabetic peripheral angiopathy without gangrene (a chronic condition where the body either doesn't produce enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels with peripheral artery disease affecting the blood vessels of the limbs). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/25/25, showed the resident was cognitively intact and required substantial assistance. Review of the resident's June 2025 Physician Order Sheet (POS) showed the following:-An order, dated 12/03/25, for Lantus U-100 Insulin (long-acting insulin) solution 100 unit/milliliter (ml), 10 units subcutaneous (under the skin) once a day at 7:00 A.M.;-A current order for Novolog U-100 Insulin (fast acting insulin) solution 10 unit/ml. Administer subcutaneously per following sliding scale;-If blood sugar measured less than 70 milligrams/deciliter (mg/dL), call physician;-If blood sugar measured 70 mg/dL to 130 mg/dL, administer 0 units of insulin;-If blood sugar measured 131 mg/dL to 180 mg/dL, administer 2 units of insulin;-If blood sugar measured 181 mg/dL to 240 mg/dL, administer 4 units of insulin;-If blood sugar measured 241 mg/dL to 300 mg/dL, administer 6 units of insulin;-If blood sugar measured 301 mg/dL to 350 mg/dL, administer 8 units of insulin;-If blood sugar measured 351 mg/dL to 400 mg/dL, administer 10 units of insulin;-If blood sugar measured greater than 400 mg/dL, administer 12 units of insulin and call the physician; -Special instructions to offer snack if meal isn't within 5 to 10 minutes of administration. Review of the resident's blood sugar dated 06/25/25, at 6:40 A.M., showed it measured 141 mg/dl. 2. Review of Resident #1's face sheet (showed the following:-admission date of 02/28/22;-No diagnoses of diabetes. Review of the resident's discharge Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/25/25, showed the resident required substantial assistance for transfers.Review of the resident's June 2025 POS showed no orders for insulin administration. Review of the resident's nurses' notes showed the following:-On 06/25/25, at 6:10 A.M. , Licensed Practical Nurse (LPN) A said an aide said the resident was not acting right. Upon entering room, the resident was observed sitting in his/her wheelchair, eyes open and fixed on the ceiling, drooling, and entire body was shaking. The resident appeared to be having a seizure. The resident would not respond to verbal commands. The resident's pupillary light response was appropriate. The resident vital signs were stable. The resident was not at baseline. Staff notified the physician and received an order to send to the resident to the hospital. Staff notified the resident's next of kin. Emergency Medical Services (EMS) arrived to transport the resident. Staff notified the DON and called a report to the hospital;-On 06/25/25, at 9:57 A.M. , LPN A said the resident was having possible seizure activity. The resident was up front to monitor resident's condition. Resident #1 was sitting by another resident and that resident that was diabetic. The LPN administered Resident #2's medication to Resident #1 who was not diabetic. Staff notified the hospital, the DON, the physician, and the resident's family of the medication error. The resident was asymptomatic from the medication error;-On 06/25/25, at 1:11 P.M., staff made a medication error note. The DON said the