STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265464	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ozark Riverview Manor	1200 West Hall, Ozark, MO 65721

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43193 Based on interview and record review, the facility failed to maintain an effective system of records and disposition of controlled medications when staff could not locate two cards of a controlled medications and failed to destroy the discontinued controlled medication in a timely fashion for one resident (Resident #1). The facility census was 56. On 04/02/24, the Assistant Director of Nursing (ADON) was notified of the Past Non-Compliance that occurred on 04/01/24. The ADON notified the physician, the Director of Nursing (DON), and the Administrator. The Administrator notified the Ozark Police Department. The DON and ADON completed an narcotic count audit. Administration interviewed staff and residents and reviewed the camera surveillance. The Administrator suspended the employee pending completion of the investigation. Administration completed in-service education with all licensed nurses and certified medication technicians (CMT) regarding controlled substances. The noncompliance was corrected on 04/10/24. Review of the facility's policy titled Controlled Substances, dated 04/2007, showed the following: -The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of Schedule II and other controlled substances; -Only authorized licensed nursing and/or pharmacy personnel shall have access to Schedule II controlled drugs maintained on premises; -Controlled substances must be counted upon delivery. The nurse receiving the order, along with the person delivering the medication order, must count the controlled substances together. Both individuals must sign the designated narcotic record; -If the count is correct, a control sheet must be made for each substance. Do not enter more than one prescription per page. This record must contain: name of resident, name and strength of the drug, quantity received, number on hand, name of physician, prescription number, name of issuing pharmacy, dated and time received, time of administration, method of administration, signature of person receiving medication and signature of nurse administering medication; -Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services (DON) or Designee; (continued on next page)

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	-The Director of Nursing Services or Designee shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility parties, and shall give the Administrator a written report of such findings; -When a resident or patient is transferred or discharged from the facility, Schedule II drugs may not be given to the resident to take with them and may not be returned to the pharmacy, but must be destroyed in accordance with established policies. Review showed the facility did not provide a policy related to destruction of controlled medications. 1. Review of Resident #1's face sheet (a document that gives a patient's information at a quick glance) showed the following: -admitted [DATE] and discharge date of [DATE]; -Diagnoses included arthritis of the left knee and dementia. Review of the resident's care plan, revised 08/02/23, showed the following: -The resident had a potential for pain related to knee replacement with a wound infection; -Anticipate the resident's need for pain relief and respond immediately to any complaint of pain; -Monitor, record, and report to the nurse any signs or symptoms of non-verbal pain; -Monitor, record, and report to the nurse resident complaints of pain or requests for pain treatment; -Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain; -Report to the nurse any change in usual activity attendance patterns or refusal to attend activities related to signs, symptoms or complaints of pain or discomfort. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 03/06/24, showed the following: -Cognitively intact; -The resident had occasional pain and was on a scheduled pain medication regimen. Review of the resident's April 2024 Physician's Order Sheet (POS) showed the following: -An order, dated 07/21/23 and discontinued 07/25/23, for oxycodone HCL (a drug to treat moderate to severe pain) 5 milligram (mg) tablet, give 5 mg by mouth (PO) every four hours as needed for severe pain with maximum daily amount of 30 mg. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's July 2023 Medication Administration Record (MAR) showed staff did not administer oxycodone to the resident from 07/21/23 through 07/25/23. Review showed the facility did not provide a narcotic control sheet for the oxycodone. Review of the facility's investigation, dated 04/02/24, showed the following: -On 04/02/24, at approximately 8:30 A.M., it was reported to the ADON there was a potential discrepancy in the narcotic count; -An audit was completed and it was noted narcotics for the discharged resident had been removed from the cart. The resident had discharged the afternoon of 04/01/24; -The resident's narcotics had not been destroyed by nurse leadership as the resident was just discharged ; -An investigation was initiated by the facility; -Upon completion of the investigation, the facility acknowledged there was sufficient evidence to support employee Licensed Practical Nurse (LPN) E had diverted what is believed to be unknown medication from the facility. During an interview on 04/18/24, at 1:18 P.M., CMT D said the following: -When he/she arrived at work, he/she counted medications with the night nurse; -They first counted the number of medication cards and bottles of narcotics and then the total amount of pills and ensured both counts matched the narcotic sheets; -If he/she noticed a discrepancy, he/she checked the computer to see if a dose was given and not documented on the narcotic sheet. If a discrepancy remained, he/she notified the ADON and did not accept the cart until the discrepancy was resolved; -On 04/02/24, he/she pulled a medication card out of the cart and the number did not correspond with the narcotic sheet. He/she immediately took this to the ADON and the ADON found them signed as given in the computer and not marked on the narcotic sheet; -Later the same day, he/she emptied a card of narcotics and went to mark it off on the narcotic record and notices the narcotic record had two cards of Norco marked off with his/her signature forged on the narcotic sheet. He/she immediately stopped what he/she was doing and took this to the ADON and that prompted a search of both the CMT and the nurses' carts; -He/she counted with LPN E that morning. During an interview of 04/18/24, at 4:18 P.M., LPN B said the following: -When he/she and LPN E counted the medication, the resident's oxycodone was in the cart; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she knew this because he/she counted this medication since 07/2023. -On 04/01/24, he/she and LPN E counted the medications in the nurses' cart together; -When he/she counted with the oncoming nurse, the oncoming nurse had the cart and he/she gave the numbers from the narcotic book. During an interview on 04/18/24, at 1:55 P.M., LPN C said the following: -When he/she arrived at work, he/she counted medications with the night nurse on the nurses' cart and the CMT counted medications with the same nurse on the CMT cart; -They counted the number of narcotic cards and then the number of pills to ensure they were the same as the narcotic record; -If he/she noticed a discrepancy, he/she did not accept the cart and notified the ADON immediately. At times, the ADON oversaw the counts; -When he/she gave a narcotic medication, he/she documented this in the computer and in the narcotic log that showed the amount of pills and cards. During an interview on 04/18/24, at 11:45 A.M., Registered Nurse (RN) A said the following: -CMTs count medications with the next shift; -When nursing or CMTs gave a narcotic, they documented this in the narcotic book with the time, their initials, date given and how many pills left; -If he/she noticed a discrepancy, he/she would first recount the medication, not take control of the medication cart until the count was correct, and notified the DON; -The facility required two RNs to destroy medications. Until the medications were destroyed, the medications remained in the cart and nursing staff or CMTs counted them daily. During an interview on 04/18/24, at 2:11 P.M., the ADON said the following: -She found the narcotic log for adding or removing cards of medication showed LPN E removed four cards of oxycodone, but the ADON realized the resident only had two cards of this medication; -She looked for the narcotic log that showed the amount of pills for the oxycodone and could not find it and never did find it; -The resident's oxycodone was not in the cart. The resident had one card of 30 pills and one card of 12 pills and he/she never used that medication. During an interview on 04/18/24, at 3:23 P.M., the DON said the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nursing staff should have destroyed the resident's oxycodone a long time ago if it was discontinued on 07/25/23; -Nursing staff should have pulled the oxycodone off the cart the day it was discharged . During an interview on 04/18/24, at 3:52 P.M., the Administrator said the following: -The DON and ADON destroyed medications and she had a discussion with the DON and ADON about how long the resident's oxycodone stayed in the cart; -The DON and ADON should have destroyed the oxycodone; -She was unable to account for 42 pills of oxycodone and all indicators pointed to LPN E took the medication. MO00234123