STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265496	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Puxico Nursing and Rehabilitation Center	540 North Highway 51 Puxico, MO 63960

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality.

47678

Based on observation, interview, and record review, the facility failed to follow physician's orders for three residents (Resident #21, #23 and #33) out of 12 sampled residents. The facility's census was 31.

Review of the facility's policy titled, Administering Medications, revised April 2019, showed:

- Medications are administered in a safe and timely manner, and as prescribed;

- Medications are administered in accordance with prescriber orders;

- Medication errors are documented, reported, and reviewed by the Quality Assurance Performance Improvement (QAPI) committee to inform process changes and or the need for additional staff training.

1. Review of Resident #21's medical record showed:

- Diagnoses of type 1 diabetes mellitus (an autoimmune disease that leads to the destruction of insulin-producing pancreatic beta cells);

- An order for Humalog (type of insulin) injection per sliding scale subcutaneously (under the skin) before meals and at bedtime for blood sugar of 101-150 = 2 units, 151-200 = 3 units, 201-250 = 4 units, 251-300 = 5 units, 301-350 = 6 units, and a blood sugar greater than 351, give 7 units, dated 06/17/24.

- No documentation staff notified the physician of the resident's refusal of the physician ordered Humalog insulin or a different dosage administered per the resident's request .

Review of the resident's Medication Administration Record (MAR), dated June 2024, showed:

- On 06/04/24 at 7:30 A.M., the resident's blood sugar was 348 and 2 units of Humalog was administered;

- On 06/04/24 at 12:00 P.M., the resident's blood sugar was 425 and 4 units of Humalog was administered due to the resident refused the physician ordered dosage and requested 4 units;

(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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 06/13/24 at 07:30 A.M., the resident's blood sugar was 408 and 4 units of Humalog was administered due to the resident refused the physician ordered dosage and requested 4 units; - On 06/21/24 at 9:00 P.M., the resident's blood sugar was 314, and 2 units of Humalog was administered due to the resident refused the physician ordered dosage and requested 4 units; - On 06/22/24 at 12:00 P.M., the resident's blood sugar was 351 and 6 units of Humalog was administered; - The resident had 28 refusals of the physician ordered insulin injections for elevated blood sugars. Review of the resident's MAR, dated 07/1/24 through 07/23/24, showed the resident had 32 refusals of the physician ordered insulin injections for elevated blood sugars. During an interview on 07/24/24 at 10:00 A.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) said the resident frequently refused his/her Humalog or would request a different dosage than what was ordered. They would expect nurses to administer medications as ordered. 2. Review of Resident #23's medical record showed diagnoses of diabetes mellitus, congestive heart failure (the heart does not pump blood as well as it should), chronic pain, atrial fibrillation (abnormal heart beat), and high blood pressure. Review of the resident's Physician Order Sheet, dated June 2024, showed an order to discontinue Actos (a medication used to control blood sugar levels), undated. Review of the resident's progress note, dated 06/25/24, showed the physician saw the resident and wrote an order to discontinue the Actos. Review of the resident's Medication Administration Record (MAR), dated 06/01/24 - 07/23/24, showed: - On 06/26/24 - 07/23/24, the facility administered Actos to the resident after the order was discontinued; - The resident received 28 doses of Actos after the medication was discontinued by the physician. 3. Review of Resident #33's medical record showed: - Diagnoses of heart failure, diabetes mellitus, traumatic brain injury, and chronic pain; - An order for lab work for hemoglobin A1C (blood test that shows the average level of blood sugar in the bloodstream over time), complete blood count (CBC - a blood test that measures the amount of different cells and substances in the blood), comprehensive metabolic panel (CMP - blood test that measures different substances in the blood), lipid panel (a test that measures cholesterol and other fats in the blood), dated 06/24/24; - No documentation of the hemoglobin A1C, CBC, CMP, and lipid panel blood test results ordered on 06/24/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/23/24 at 2:30 P.M., Registered Nurse (RN) A said when orders were written, the nurse receiving the order should process it. During an interview on 07/22/24 at 12:40 P.M., the DON said the orders for Resident #33's lab work were not processed and therefore not completed. During an interview on 07/22/24 at 2:10 P.M., the DON and the Administrator said they expect orders to be followed as written.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49150 Based on interview and record review, the facility failed to provide documentation of ongoing assessment and monitoring for one (Resident #21) out of one sampled resident receiving dialysis (process for removal of waste and excess water from the blood due to kidney failure) after returning from treatments. The facility census was 31. Review of the facility's policy titled, Hemodialysis Catheters-Access and Care of, last revised 2001, showed: Care of arteriovenous fistula (a surgical connection made between an artery and a vein for dialysis access) and arteriovenous graft (a type of access used for hemodialysis): - Check for signs of infection (warmth, redness, tenderness, or edema) at the access site when performing routine care and at regular intervals; -Check the color and temperature of the fingers, and the radial (smaller bone in the forearm) pulse of the access arm when performing routine care and at regular intervals; - Check patency (open/unobstructed) of the site at regular intervals. Palpate the site to feel the thrill (a vibration caused by blood flowing through the fistula), or use a stethoscope to hear the whoosh or bruit (an audible vascular sound associated with turbulent blood flow) of blood flow through the access. - Immediately following dialysis treatment, if the dialysis dressing becomes wet, dirty, or not intact, the dressing shall be changed by a licensed nurse trained in this procedure. Mild bleeding from the site (post dialysis) can be expected. Apply pressure to insertion site and contact the dialysis center for instructions. If there is major bleeding from the site (post dialysis), apply pressure to the insertion site and contact emergency services and the dialysis center. Verify that clamps are closed on the lumens (dialysis tubing). This is a medical emergency. Do not leave the resident alone until emergency services arrive; - The nurse should document in the resident's medical record every shift as follows: Location of catheter; Condition of the dressing (interventions if needed); If dialysis was done during the shift; Any part of the report from the dialysis nurse post dialysis being given; and Observations post dialysis. Review of Resident #21's medical record showed: - admitted on [DATE]; (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of anemia (not enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), type 1 diabetes mellitus (an autoimmune disease that leads to the destruction of insulin-producing pancreatic beta cells), hypercholestremia, (an elevated level of lipids, like cholesterol and triglycerides, in your blood), major depressive disorder (mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), high blood pressure, systolic congestive heart failure (a specific type of heart failure that occurs in the heart's left ventricle), stage 3 chronic kidney disease (kidneys do not work as well as they should to filter waste and extra fluid out of your blood), end stage renal disease (a person's kidneys cease functioning on a permanent basis), acquired absence of right leg above the knee, and dependence on renal dialysis. Review of the resident's Physician Order Sheet (POS), dated July 2024, showed: - An order to monitor the right arm fistula, site for signs/symptoms of infection every shift. Monitor dialysis graft (an access made by using a piece of soft tube to join an artery and vein in your arm), two times a day, dated 06/07/24; - No documentation of an order to assess and monitor the right arm fistula site for a thrill and bruit; - No current order for hemodialysis three times weekly on Monday, Wednesday, and Friday, last dated order was 03/03/23, from previous admission. - The facility failed to obtain an order for the assessment and monitoring of the right arm fistula site for the thrill and bruit. During interview on 07/24/24 at 10:00 A.M., the Director of Nursing (DON) said that he/she would expect nurses to assess all dialysis residents with fistulas by assessing the site for signs or symptoms of infection, thrill, and bruit every shift. During an interview on 07/24/24 at 10:30 A.M., Licensed Practical Nurse (LPN) F said a resident's dialysis fistula was assessed for signs or symptoms of infection and documented in the Treatment Administration Record (TAR) every shift, but not the thrill and bruit.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 47447 Based on interview and record review, the facility failed to ensure two nurse aides (NA) completed a nurse aide training program within four months of his/her employment in the facility. This deficient practice had the potential to affect all residents in the facility. The facility census was 31. Review of the facility's policy titled, Nurse Aide Qualification and Training Requirements, revised August 2022, showed: - The facility will employ any individual as a nurse aide for more that four months full-time, temporary, per diem, or otherwise, unless: that individual is competent to provide designated nursing care and nursing related services; and that individual has completed a training program and competency evaluation program, or a competency evaluation program approved by the state; or that individual has been deemed competent as provided in 483.150(a) and (b) of the requirements of participation; - Nursing assistants failing to successfully complete the required training program within the first four months of their date of employment may be terminated from employment or may be reassigned to non-nursing related services. 1. Review of a NA D's Certified Nursing Assistant (CNA) training record showed: - Hire date of 10/26/23; - Classroom and on the job training started on 05/07/24; - The facility failed to ensure the completion of the program within four months of NA D's hire date. 2. Review of the NA E's CNA training record showed: - Hire date of 12/28/23; - Scheduled to start the next class on 8/14/24; - The facility failed to ensure the completion of the program within four months of NA E's hire date. During an interview on 07/24/24 at 12:30 P.M., the Director of Nursing (DON) said she was aware the facility had dropped the ball and she did expect NA's to have completed training within four months of hire. During an interview on 07/24/24 at 2:15 P.M., the Administrator said she expected NA's to have completed training within four months of hire.

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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. 47678 Based on interview and record review, the facility failed to ensure staff reconciled narcotics (a process that allows one staff to reconcile the exact narcotic inventory on hand with another staff) at each shift change for one out of two medication carts. This practice had the potential to affect all residents. The facility census was 31. Review of the facility's policy titled, Controlled Substances, last revised November 2022, showed: - The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications; - Controlled substances inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow up; - The system of reconciling the receipt, dispensing, and disposition of controlled substances includes records of personnel access and usage, medication administration records, declining inventory records, and destruction/waste/return to pharmacy records; - Nursing staff count controlled medication inventory at the end of each shift; - The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the Director of Nursing (DON) services; - The consultant pharmacist or designee routinely monitors controlled substance storage records. Review of the Nurse Medication Cart Eight Hour/Shift Verification of Controlled Substances Count log, dated 06/14/24 - 07/23/24, showed: - No documentation of the narcotic reconciliation completed by staff with 51 out of 79 opportunities missed. During an interview on 07/23/24 at 9:08 A.M., Registered Nurse (RN) A said he/she did count with the off going nurse this morning, but just forgot to sign the log. The nurses compare the quantity on the individual narcotic sheet to the actual quantity of medication. During an interview on 07/23/24 at 9:18 A.M., the DON said she expects the nurses to count and fill out the count verification sheet each shift change. During an interview on 07/23/24 at 9:25 A.M., the Administrator said nurses should count narcotics at each shift change.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47678 Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) when medications were administered. There were 26 opportunities with two errors made, for an error rate of 7.69%. This practice affected two residents (Resident #30 and #23) of five sampled residents. The facility census was 31. Review of the facility's policy titled, Administering Medications, last revised April 2019, showed: - Medications are administered in accordance with prescriber orders; - Medication errors are documented, reported, and reviewed by the Quality Assurance Performance Improvement (QAPI) committee to inform process changes and or the need for additional staff training; - The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication. 1. Review of Resident #23's medical record showed: - Diagnosis of diabetes mellitus (chronic condition that affects the way the body processes blood sugar); - An order on the June 2024 Physician Order Sheet (POS) to discontinue Actos (a medication used to control blood sugar levels), undated; - A progress note, dated 06/25/24, the physician saw resident and wrote an order to discontinue Actos. Observation on 07/23/24 at 8:00 A.M., of the resident's medication administration showed: - Registered Nurse (RN) A administered Actos 15 milligrams (mg) to the resident; - RN A administered a discontinued medication to the resident. During an interview on 07/23/24 at 2:30 P.M., RN A said Actos should have not been given to the resident since there was an order to discontinue it. 2. Review of Resident #30's medical record showed: - Diagnoses of dorsalgia (back pain) and deficiency of other vitamins; - An order for calcium (a mineral used to build and maintain strong bones) 500 mg two times a day. Observation on 07/23/24 at 7:46 A.M., of the resident's medication administration showed: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RN A administered calcium 500 mg with Vitamin D 200 international units (IU) tablet to the resident; - RN A failed to administer the medication as ordered. During an interview on 07/23/24 at 9:05 A.M., RN A said only the calcium tablet should have been given, not the calcium tablet with Vitamin D. During an interview on 07/24/24 at 2:10 P.M., the Director of Nursing (DON) and the Administrator said they would expect to have a medication error rate of less than 5%.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 47678 Based on observation, interview, and record review, the facility failed to ensure two vials of Aplisol (a solution used during a tuberculosis (a serious bacterial infection that mainly affects the lungs) test were dated when opened. This had the potential to affect all residents. The facility's census was 31. Review of the facility's policy titled, Medication Labeling and Storage, revised February 2023, showed multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Review of the manufacturer's recommendations for Aplisol, revised November 2013, showed the medication will be discarded 30 days after date opened. Observation on 07/23/24 at 9:10 A.M., of the locked refrigerator in the medication room showed two opened vials of Aplisol solution not dated. During an interview on 07/23/24 at 9:11 A.M., Registered Nurse (RN) A said multi-dose vials should be dated when opened and discarded if not used in 28 days. During an interview on 07/24/24 at 2:10 P.M., the Director of Nursing (DON) said multi-dose vials should be dated when opened and discarded 20 to 30 days after opened.