STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265534	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Care Center	4401 North Hanley Road Saint Louis, MO 63134

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 27723 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 27 opportunities for errors, six errors occurred, resulting in an 22.22% medication error rate (Resident #6). The census was 112. Review of the facility's Medication Administration Policy, dated 6/26/24, showed the following: -Purpose: Medications are administered by licensed nurses and other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice. It is the policy of this facility to ensure the safe and effective administration of of all medications by utilizing best practice guidelines; -Policy: General Medication Administration Practice: C. Identify resident by photo in the medication administration record (MAR). J. Ensure that the six rights of medication administration are followed: 1. Right resident, 2. Right drug, 3. Right dosage, 4. Right route, 5. Right time, 6. Right documentation. K. Review MAR to identify medication to be administered. L. Compare medication source with the MAR to verify the resident's name, medication name, form, dose, route and time. O. Administer the medication as ordered accordance with manufacturer specifications. R. Sign MAR after administered. U. Correct any discrepancies and report to the Nurse Manager. Review of Resident #6's Physician's Order Sheet (POS), dated 7/2024, showed the following: -Metoprolol (medication used to treat high blood pressure) 50 milligrams (mg) by mouth once a day; -Quetiapine Fumarate (medication used to depression) 100 mg by mouth twice a day; -Cholecalciferol (Vitamin D) 25 microgram (mcg) two tablets by mouth; -Sertraline (medication used to treat depression) 25 mg by mouth once a day; -Spironolactone (medication used to treat high blood pressure) 25 mg by mouth once a day; -Klor-Con M10 (potassium) extended release five tablets twice a day; -Pantoprazole (medication used to treat acid reflux) 40 mg by mouth once a day; (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Montelukast (medication used to prevent asthma attacks) 10 mg once day; -Metformin (medication used to treat diabetes) 500 mg by mouth twice a day; -Meloxicam (medication used to treat osteoarthritis) 5 mg by mouth once a day; -Gabapentin (medication used to treat nerve pain) 100 mg by mouth three times per day; -Lasix (medication used to treat high blood pressure) 40 mg by mouth once a day; -Divalproex (used to treat seizures and bipolar disorder) 500 mg 3 tablets by mouth twice a day; -Buspirone (used to to treat anxiety) 15 mg four times per days; -Symbicort Inhalation (inhaled steroid used to treat asthma) 160-4.5 mcg aerosol two puff inhale twice a day; -Allopurinol (used to treat gout and kidney stones) 100 mg once a day; -Haloperidol (antipsychotic used to treat certain mood disorders) 5 mg twice a day. Observation on 7/29/24 at 10:25 A.M., showed the resident sat at the nurses station. He/She said he/she was waiting for his/her medications. Certified Medication Technician (CMT) A removed a Albuterol 90 mcg inhaler from the drawer, shook it and handed it to the resident to self administer. No instructions were given to the resident on the inhaler's use. CMT A removed multiple medications from the drawer which included: haloperidol 2 mg by mouth, haloperidol 5 mg, allopurinol 100 mg, buspirone 15 mg, divalprox 500 mg, gabapentin 100 mg, metformin 500 mg metoprolol 50 mgt, potassium 10 mg 5 tablets, pantoprazole 40 mg, quetiapine 100 mg, spironolactone 25 mg and Vitamin D 25 mcg two tablets, checked the MAR and placed the medications in a med cup. After administering the medications, CMT A said he/she administered the wrong inhaler. He/She instructed the resident to self administer the Symbicort inhaler and drink a cup of water afterwards. CMT A failed to administer the Lasix 40 mg, Meloxicam 15 mg and sertraline 25 mg. During an interview on 7/29/24 at 2:00 P.M., CMT A said he/she checked the resident's MAR/POS and saw orders for 2 mg and 5 mg of haloperidol. He/She reported the medications to the Charge Nurse to verify after he/she administered the medication. CMT A should have instructed the resident to rinse his/her mouth after the Symbicort inhaler. He/She made a mistake when he/she failed to administer the resident's medications and he/she should not have administered the albuterol inhaler. During an interview on 8/3/24 at 9:35 P.M., the DON said a medication error was made after a telehealth visit was completed. The Nurse Practitioner was unable to enter the order change and sent an email to the Assistant Director of Nurses (ADON). The ADON entered the haloperidol 5 mg order but failed to remove the 2 mg order. The medication error was corrected once this surveyor brought it to the facility's attention. She expected staff to administer medications as ordered. During an interview on 8/1/24 at 2:28 P.M., the Administrator said when staff pass medications and a problem is found, it should immediately be reported to the Charge Nurse and Director of Nursing. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00238742

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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. 27723 Based on observation, interview and record review, the facility failed to prevent a significant medication error. Staff failed to transcribe antipsychotic medication as ordered for one of six sampled residents, resulting in the resident receiving the incorrect dosage of an antipsychotic medication (Resident #6). The census was 112. Review of Resident #6's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/4/24, showed the following: -Diagnoses of high blood pressure, anxiety and depression; -No cognitive impairment; -No mood problems; -No behavior problems; -Receives antipsychotic medicine: yes. Review of the facility's Medication Administration Policy, dated 6/26/24, showed the following: -Purpose: Medications are administered by licensed nurses and other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice. It is the policy of this facility to ensure the safe and effective administration of of all medications by utilizing best practice guidelines; -Policy: General Medication Administration Practice: C. Identify resident by photo in the medication administration record (MAR). J. Ensure that the six rights of medication administration are followed: 1. Right resident, 2. Right drug, 3. Right dosage, 4. Right route, 5. Right time, 6. Right documentation. K. Review MAR to identify medication to be administered. L. Compare medication source with the MAR to verify the resident's name, medication name, form, dose, route and time. O. Administer the medication as ordered accordance with manufacturer specifications. R. Sign MAR after administered. U. Correct any discrepancies and report to the Nurse Manager. Review of Resident #6's Physician's Order Sheet (POS), dated 6/2024, showed the following: -Haloperidol (antipsychotic used to treat certain mood disorders) 2 milligram (mg) three times per day; -Haloperidol 5 mg twice a day, ordered 6/21/24. Review of the resident's MAR, dated 6/2024, showed the following: -Haloperidol 2 mg by mouth three times per day; (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff documented as given: 7:00 A.M.: 6/1, 6/3/24 through 6/30/24. 11:00 A.M.: 6/1, 6/3/24 through 6/30/24. 4:00 P.M.,: 6/1, 6/3/24 through 6/30/24. 6/2/24: Received other medication for behavior outburst; -Haloperidol 5 mg twice a day, start date of 6/21/24; -Staff documented as given: 7:00 A.M.: 6/21 through 6/30/24. 4:00 P.M.: 6/21 through 6/30/24. Review of the resident's progress note, dated 6/21/24, showed the following: -Seen by telehealth psych Nurse Practitioner; -New orders received and updated. Review of the resident's POS, dated 7/2024, showed the following: -Haloperidol 2 mg three times per day; -Haloperidol 5 mg twice a day. Review of the resident's MAR, dated 7/2024, showed the following: -Haloperidol 2 mg by mouth three times per day; -Staff documented as given: 7:00 A.M.: 7/1 through 7/7/24, 7/11 and 7/26: hospitalized . 7/8/24 through 7/25/24, 7/27 through 7/29/24. 11:00 A.M.: 7/1/24 through 7/7/24, 7/11 and 7/26: hospitalized . 7/8/24 through 7/25/24, 7/27 through 7/29/24. 4:00 P.M.: 7/1 through 7/7/24, 7/11 and 7/26 hospitalized . 7/8/24 through 7/25/24, 7/27 through 7/29/24.; -Haloperidol 5 mg twice a day; -Staff documented as given: 7:00 A.M.: 7/1 through 7/7/24, 7/11 and 7/26: hospitalized . 7/8/24 through 7/25/24, 7/27 through 7/29/24. 4:00 P.M.: 7/1 through 7/7/24, 7/11 and 7/26: hospitalized . 7/8/24 through 7/25/24, 7/27 through 7/29/24. Review of the resident's care plan, updated 7/11/24, showed the following: -Problem: Resident at risk for adverse reactions related to psychotropic medication; -Intervention: Follow up with psych doctor as needed. Medication as ordered. Pharmacy review quarterly and as needed. Labs as ordered. Observation on 7/29/24 at 10:25 A.M., showed the resident sat at the nurses station. He/She said he/she was waiting for his/her medications. Certified Medication Technician (CMT) A removed multiple medications from the drawer which included: haloperidol 2 mg by mouth and haloperidol 5 mg. He/She checked the MAR and administered the medications to the resident. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/29/24 at 2:00 P.M., CMT A said he/she checked the resident's MAR/POS and saw orders for 2 mg and 5 mg of haloperidol. He/She reported the medications to the Charge Nurse to verify after he/she administered the medication. CMT A should have reported the medications to the Charge Nurse prior to administering the medications. During an interview on 8/3/24 at 9:35 P.M., the DON said a medication error was made after a telehealth visit was completed on 6/21/24. The Nurse Practitioner was unable to enter the order change and sent an email to the Assistant Director of Nurses (ADON). The ADON entered the haloperidol 5 mg order but failed to remove the 2 mg order. The medication error was corrected once this surveyor brought it to the facility's attention. She expected staff to transcribe and administer medications as ordered. MO00238742

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 27723 Based on observation, interview and record review, facility staff failed to follow acceptable infection control practices to prevent the spread of infection, Covid 19 (respiratory virus spread by breathing, coughing and sneezing). The facility had active Covid 19 infections on all halls per signage upon entering. The signs instructed all visitors and staff to wear an N95 mask. Visitors and staff failed to wear N95 masks and or failed to wear them appropriately. This had the potential to affect all residents. The census was 112. Review of the facility's policy on Personal Protective Equipment, updated 6/26/24, showed the following: -Purpose: Thee facility promotes appropriate use of personal protective equipment (PPE) to prevent the transmission of pathogens to residents, visitors and other staff; -Policy: A. All staff who have contact with residents and or their environments must wear PPE equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids or potential infectious materials in the facility; -Respiratory protection: 1. Wear a N95 or higher level respirator to prevent inhalation of pathogens transmitted by the air born route. Observation on 7/29/24, showed he following: -8:45 A.M., this surveyor noted on the front door a sign that said: Positive Covid 19 in the facility. All staff and visitors must wear N95 masks upon entering; -9:00 A.M.: Initial round in the facility: Two Certified Nurse Aid's, one on A hall without a mask, CNA B in common area with mask not covering nose; -10:03 A.M.: Two employees from pest control company in hall and resident room without a mask; -10:07 A.M.: Soda vendor in common area without a mask; -10:25 P.M.: Maintenance worker in common area and C hall without mask; -1:25 P.M.: Two staff without masks in common area near residents without masks. During an interview on 7/29/24 at 9:16 A.M., Certified Medication Technician (CMT) G said staff and visitors are to wear N95 masks while in the facility. During an interview on 7/29/24 at 10:15 A.M., Worker C and D from the pest control company said they saw the sign on the front door regarding positive Covid 19 in the building. Staff didn't instruct them to don a mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/29/24 at 1:45 P.M., the Administrator and Director of Nurses said all staff and visitors are to wear N95 masks while in the facility due to the Covid 19 outbreak.