STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265545	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Memorial Healthcare Facility	1218 West Locust Bolivar, MO 65613

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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 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 ensure establish an accurate system of administration of narcotic pain medications when staff failed to accurately document administration of narcotic pain medications and administer them within the parameters of physicians' orders for two residents (Resident #1 and Resident #2). Ten residents were sampled out of a facility census of 100. Review of the facility's policy titled Medication Administration and Documentation, revised 06/2024, showed the following: -The facility maintains a standard procedure for admission of drugs by licensed personnel with a physician's order; -Purpose of the policy was to outline correct procedure for documentation of bedside medication administration utilizing the Medication Administration Record (MAR) in the Patient Care System (PCS). To provide a medication administration system that enhances patient safety by providing a means for the verification of the 5 Rights. To provide a framework for timing of medication administration based on the nature of the medication and its clinical application to ensure safe and timely administration; -Non-time critical scheduled medications are those for which a longer or shorter interval of time since the previous dose does not significantly alter the therapeutic effect or otherwise cause harm; -Medications not eligible for scheduled dosing times will have a time specified by the provider in the initial order such as stat doses (to be administered immediately or within 15 minutes); first doses or loading doses timed to bring plasma or tissue concentrations to an effective concentration quickly such as vancomycin (an antibiotic), digoxin (a medication used to treat heart failure and heart rhythm problems) and amiodarone bolus dose (a medication use to treat heart rhythm problems); one time doses such as those specifically timed for a procedure; doses timed for obtaining serum drug levels; and medications prescribed on an as-needed basis; -The medication should be administered as soon as possible after the dose has been prepared, particularly a medication prepared for parenteral administration (drugs given by injection or infusion). The medication dosage will not be removed from its packaging or labeling until immediately before administration of the drug; (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	-For the safety of the patient, the provider will observe the following factors: right patient-ask patient/resident to verify name and date of birth, compare name bracelet and/or resident photo identification and MAR; right time-check MAR for proper time medication is to be given; right medication- compare medication packet to medication name on MAR and doctor's order sheet if indicated; right route-check MAR for correct route and site for injections; and right dose-compare dosage on medication packet to dosage on MAR; -As needed medications shall be charted in the MAR. Laboratory data and any subsequent re-assessment after the administration is to be completed through an assessment or nursing intervention in PCS. The patient's report of his/her experience of the medications effects must also be documented. Nursing may incorporate patient preference and administer a less potent or non-opioid product if ordered for a lesser pain scale. Documentation of patient choice must be included in the pain assessment. A more potent narcotic cannot be given without a provider's order regardless of patient preference. 1. Review of Resident #1's face sheet (a document that gives a patient's information at a quick glance) showed an admitted [DATE]. Review of the resident's current diagnosis sheet showed the resident had diagnoses that included chronic pain syndrome and other chronic pain. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 08/20/24, showed the following: -The resident was cognitively intact; -The resident received scheduled and as needed (PRN) pain medications and non-medication intervention for pain; -The resident frequently had pain; -Pain occasionally effected sleep, interfered with therapy activities, and day to day activities; -The resident's pain intensity was 7 on a pain scale of 0 to 10 and the resident described it as moderate; Review of the resident's care plan, reviewed 10/02/24, showed the following: -The resident was at risk for pain due to paraplegia (loss of muscle function and sensation in the lower half of the body, including legs, feet and toes), lumbar spondylosis (degenerative disease of the lower back), chronic kidney disease and spinal compression fracture. -Consider pain assessment and develop pain management program with the resident. The resident had pain medication that he/she wished to ask for when in pain. He/she did not wish to be woken up during the night. Review of the resident's October 2024 Physician's Order Sheet (POS) showed an order, dated 07/23/24, for oxycodone (a pain medication), 5 milligrams (mg) PO (by mouth) every 4 hours PRN. (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 October 2024 Medication Administration Record (MAR) showed on 10/16/24, at 1:40 A.M., Licensed Practical Nurse (LPN) A administered PRN oxycodone 5 mg tablet to the resident. Review of the resident's Controlled Drug Record showed on 10/16/24, at 2:00 A.M. and 10:20 P.M., LPN A administered oxycodone 5 mg tablet to the resident. Review of the resident's October 2024 MAR showed on 10/17/24, at 2:18 A.M., LPN A administered PRN oxycodone 5 mg tablet to the resident. Review of the resident's Controlled Drug Record showed on 10/17/24, at 2:20 A.M., LPN A administered oxycodone 5 mg tablet to the resident. During an interview on 10/22/24, at 11:17 A.M., the resident said the following: -He/she took pain medications; -He/she took pain medications during the night once in a while when he/she needed one; -He/she normally fell asleep around 10:30 P.M. and slept until 5:00 A.M.; -He/she had not requested pain medications in the middle of the night for over a month; -When LPN A worked, the LPN documented the resident took pain medications in the middle of the night, but other nurses did not. He/she believed it was odd; -He/she did not take pain medications in the middle of the night on 10/16/24 or 10/17/24. He/she knew this because he/she would have to wake up and drink water when taking the medication. During an interview on 10/22/24, at 1:09 P.M., Certified Medication Technician (CMT) A said the following: -He/she noticed starting a couple months ago that twice nightly at the same or similar times, the resident received PRN oxycodone; -He/she asked the resident if the resident took this in the middle of the night and the resident said they did not ask for the medication in the middle of the night; -He/she told the Director of Nursing (DON) and a few days later, the DON said the medication pass was normal; -Approximately a week ago, he/she noticed the same trend start again with the resident; -He/she asked the resident and the resident said they did not take the oxycodone at night. During an interview on 10/23/24, at 1:23 P.M., LPN A said the following: -The resident sometimes asked for PRN oxycodone and when the resident asked for the medication he/she gave the medication; (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 did not know if he/she gave the PRN oxycodone on 10/16/24, at 1:40 A.M., or 10/17/24, at 2:18 A.M.; -He/she did not know where the resident's medication went and he/she could have laid the medication down in another resident's room or thrown them in the trash with another cup. During an interview on 10/24/24, at 2:08 P.M., Registered Nurse (RN) E said the following: -The resident did not complain of a lot of pain to the RN; -The resident was cognitively intact and would know if he/she received pain medication during the night; -Unless the resident woke up and complained of pain, he/she would not wake the resident up to give a PRN pain medication. During an interview on 10/24/24, at 1:37 P.M., the DON said the resident said he/she did not receive pain medication during the night that was signed out by LPN A. 2. Review of Resident #2's face sheet showed an admitted [DATE]. Review of the resident's diagnosis sheet showed the resident had diagnoses that included low back pain and other chronic pain. Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident had moderate cognitive impairment; -The resident received scheduled and PRN pain medications; -At the time of the assessment the resident did not have pain. Review of the resident's current care plan showed he/she had pain related to his/her disease process, chronic psychosocial or physical disability, and musculoskeletal pain. He/she would have his/her pain relief maintained to a satisfactory level. Review of the resident's September 2024 POS showed an order, dated 06/06/22, for hydrocodone (a narcotic pain medication) 7.5/325 mg., one tablet by mouth every four hours PRN. Review of the resident's September 2024 MAR showed on 09/19/24, at 1:00 A.M. and 3:45 A.M., LPN A administered one PRN hydrocodone 7.5/325 mg tablet to the resident; Review of the resident's Controlled Drug Record showed on 09/19/24, at 1:00 A.M. and 5:00 A.M., LPN A administered one PRN hydrocodone 7.5/325 mg tablet to the resident. Review of the resident's September 2024 MAR showed on 09/24/24, at 12:15 A.M., 1:28 A.M., and 4:45 A.M. , LPN A administered one PRN hydrocodone 7.5/325 mg. tablet to the resident. (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 Controlled Drug Record showed on 09/24/24, at 12:00 A.M. and 4:00 A.M., LPN A administered one PRN hydrocodone 7.5/325 mg tablet to the resident. Review of the resident's October 2024 POS showed an order, dated 06/06/22, for hydrocodone 7.5/325 mg., one tablet by mouth every four hours PRN. Review of the resident's October 2024 MAR showed on 10/05/24, at 1:40 A.M., 3:43 A.M., 7:47 P.M. and 7:55 P.M., LPN A administered one PRN hydrocodone 7.5/325 mg. tablet to the resident. Review of the resident's Controlled Drug Record showed on 10/05/24, at 12:00 A.M. and 4:00 A.M., LPN A administered one PRN hydrocodone 7.5/325 mg tablet to the resident. Review of the resident's October 2024 MAR showed on 10/07/24, at 1:45 A.M., LPN A administered one PRN hydrocodone 7.5/325 mg. tablet to the resident. Another staff member administered one PRN hydrocodone 7.5/325 mg. tablet to the resident at 2:54 A.M. Review of the resident's Controlled Drug Record showed on 10/07/24, at 2:55 A.M., a staff member administered one PRN hydrocodone 7.5/325 mg tablet to the resident. LPN A did not document the administration of one tablet that was signed out in the MAR at 1:45 A.M. Review of the resident's October 2024 MAR showed on 10/08/24, at 1:30 A.M. and 4:25 A.M., LPN A administered one PRN hydrocodone 7.5/325 mg. tablet to the resident. Review of the resident's Controlled Drug Record showed on 10/08/24, at 1:50 A.M. and 5:50 A.M., LPN A administered one PRN hydrocodone 7.5/325 mg tablet to the resident. Review of the resident's October 2024 MAR showed on 10/10/24, at 1:20 A.M. and 3:56 A.M., LPN A administered one PRN hydrocodone 7.5/325 mg. tablet to the resident. Review of the resident's Controlled Drug Record showed on 10/10/24, at 1:20 A.M. and 5:01 A.M., LPN A administered one PRN hydrocodone 7.5/325 mg tablet to the resident. During an interview on 10/22/24, at 1:28 P.M., CMT B said he/she noticed the resident received more PRN pain medication during the night when LPN A worked and reported this to the DON. During an interview on 10/22/24, at 2:49 P.M., the resident said he received pain medications sometimes in the middle of the night. During an interview on 10/23/24, at 1:23 P.M., LPN A said the following: -The resident always asked for pain medication when the resident woke up; -He/she told the resident to tell the other nurses when the resident was hurting; -He/she popped the residents medications and scanned them, but did not administer the medications at that time; -He/she sometimes forgot to go back and change the time he/she did administer the medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/24, at 1:37 P.M., the DON said the following: -The resident had an order for PRN hydrocodone 7.5/325 mg. every four hours; -The doses given to the resident by LPN A on 09/19/24 at 1:00 A.M. and 3:48 A.M. were not given as prescribed; -The doses given to the resident by LPN A on 09/24/24 at 12:15 A.M., 1:28 A.M. and 4:45 A.M. were not given as prescribed; -The doses given to the resident by LPN A on 10/05/24 at 1:40 A.M. and 3:43 A.M. were not given as prescribed; -The doses given to the resident by LPN A on 10/07/24 at 1:45 A.M. and 2:54 A.M. were not given as prescribed; -The doses given to the resident by LPN A on 10/08/24 at 1:30 A.M. and 4:25 A.M. were not given as prescribed; -The doses given to the resident by LPN A on 10/10/24 at 1:20 A.M. and 3:56 A.M. were not given as prescribed. During an interview on 10/24/24, at 2:08 P.M., RN E said the resident did not complain of pain throughout the day, but received PRN pain medications during the night. During an interview on 10/24/24, at 2:37 P.M., the Administrator said the doses given to the resident by LPN A on 09/19/24, 09/24/24, 10/05/24, 10/07/24, 10/08/24 and 10/10/24 were not administered as prescribed. 3. During interviews on 10/22/24, at 1:09 P.M., and on 10/24/24, at 11:36 A.M., CMT B said the following: -When he/she passed medications, he/she ensured the right medication, order, time, dose and resident; -He/she could administer PRN pain medications with an order for every four hours as needed if 3.5 hours passed since the last dose; -He/she did not prepare the medication until the medication was administered even for the residents who frequently asked for their medication. Staff should not assume a resident would need the medication and prepare it earlier than the order said; -He/she knew when he/she gave medications and watched the residents take the medication. 4. During an interview on 10/22/24, at 1:28 P.M., CMT C said when he/she passed medications, he/she ensured the right medication, order, time, dose and resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. During interviews on 10/23/24, at 1:23 P.M., and on 10/24/24, at 12:33 P.M., LPN A said the following: -He/she should not prepare a resident's medication until he/she was ready to administer the medication to a resident; -When he/she administered medications, he/she checked right resident, dose, medication, frequency, time and route, but he/she did not always follow this; -If a resident had an order for PRN pain medication to be given every four hours, he/she could give every four hours or could give up to one hour early. He/she could not give that medication 2 to 2.5 hours early. 6. During an interview on 10/24/24, at 11:56 A.M., LPN E said the following: -When he/she administered medication he checked for right resident, time, medication and route; -He/she required a physician's order before he/she administered a medication; -He/she gave medications per the physician's order; -If a resident had an order for a PRN narcotic, he/she gave the medication when the resident requested and within the timeframe specified on the physician's order; -If a resident had an order for a PRN narcotic every four hours and four hours had not passed since the last dose, he/she contacted the physician to see if he/she could administer the medication early; -He/she did not remove medications from the cart unless he/she administered the medications. 7. During an interview on 10/24/24, at 2:08 P.M., RN E said the following: -He/she required a physician's order before giving a resident a medication; -He/she ensured the right resident, medication, route, dose and time prior to administration of a medication; -If a resident had a PRN pain medication ordered for every four hours, he/she administered when the resident complained of pain but not before 3.5 to 4 hours had passed since the last PRN dose; -Staff should not remove medication from the cart early because they know the resident would ask for the medication. The removed the medication when the resident complained of pain and the appropriate time passed. 8. During an interview on 10/28/24, at 1:46 P.M., the Director of Pharmacy Services said the following: -He/she did not believe the PRN pain medication orders could be liberalized; (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 did not think it was appropriate for PRN oxycodone orders to be liberalized; -If the physician wrote an order for PRN hydrocodone every four hours then the physician meant the medication to be given no more than every four hours. 9. During an interview on 10/24/24, at 1:37 P.M., the DON said the following: -Staff informed her there were possible documentation errors with pain medications in the past, but LPN A worked six nights a week so she could not see a trend and the resident who received the medication made sense; -She expected staff to follow the right dose, time, resident and route when they administered medication; -PRN pain medication was given when the resident requested, or an appropriate assessment was made for a resident who could not ask for the medication; -Staff should not assume a resident would need medication and prepare the medication early. 10. During an interview on 10/24/24, at 2:37 P.M., the Administrator said the following: -Staff should not prepare medication early. They should remove them from the cart when the medication was due, or the resident requested medication; -Staff should administer medication as prescribed, but they could give medication one hour early or one hour late; -Nurses should know if they signed the medication out that they gave the medication. MO00243564