| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265574 | A. Building<br>B. Wing | 08/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Monroe City Manor Care Center | 1010 Highway 24 & 36 East<br>Monroe City, MO 63456 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure the range hood was free of an accumulation of grease and debris, failed to ensure the floors in the kitchen were free of a buildup of grease and debris, and failed to properly store food items. The facility census was 54.1. Review of the facility policy, Cleaning Instructions: Hoods and Filters, dated 2020, showed hoods and filters will be cleaned regularly, at least once a month. Review of the Dietary Sanitation Evaluation, dated 6/6/25 and completed by the facility's consultant dietitian, showed the hoods and filters were not clean and dust was noted. Review of the Dietary Sanitation Evaluation, dated 7/11/25 and completed by the facility's consultant dietitian, showed the hoods and filters were not clean and had dust. Observation on 8/18/25 at 10:35 A.M., of the kitchen range hood showed the following:-A moderate buildup of yellow grease and dark-colored debris on the baffle filters under the range hood;-The range hood protected a six-burner stove, flat-top griddle and a double fryer. During an interview on 8/18/25 at 10:35 A.M., the Dietary Manager said staff were supposed to clean the hood and filters weekly. She was unsure if staff cleaned the range hood last week. 2. Review of the Dietary Sanitation Evaluation, dated 6/6/25 and completed by the facility's consultant dietitian, showed the floor was not clean. Review of the Dietary Sanitation Evaluation, dated 7/11/25 and completed by the facility's consultant dietitian, showed the floor was sticky. Observation on 8/18/25 at 10:38 A.M. and on 8/19/25 at 8:53 A.M. showed an extremely heavy buildup of yellow and brown pooled grease and food debris on the floor underneath the six-burner stove, griddle, double fryer, and metal preparation counter. Yellow grease visibly ran down the front of the stove and dripped into the existing puddle of grease on the floor. During an interview on 8/19/25 at 8:53 A.M., the Dietary Manager said staff was supposed to clean the grease off the floor weekly. Staff was behind in the scheduled duties and it was overwhelming to try to get caught up. The grease trap didn't always catch the grease, and the grease leaked out inside the stove. 3. Review of the Dietary Sanitation Evaluation, dated 6/6/25 and completed by the facility's consultant dietitian, showed the floor of the walk-in freezer was not clean. Observation on 8/18/25 at 9:33 A.M. of the walk-in freezer showed a heavy accumulation of paper trash, potato wedges. and other food debris/crumbs on the floor of the unit. During an interview on 8/19/25 at 8:53 A.M., the Dietary Manager said staff were to clean spills and messes as they occurred. 4.Observation on 8/18/25 at 9:34 A.M. of the walk-in cooler showed a black crate sat on the cooler floor that held a plastic bag of liquid ice cream mix that directly touched the floor. Observation on 8/18/25 at 10:27 A.M. of the kitchenette refrigerator showed an open 1-pound stick of butter. The paper wrapper loosely covered the butter and left the butter open to air. During an interview on 8/19/25 at 8:53 A.M., the Dietary Manager said the ice cream mix should not be stored on the floor. |

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 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer and/or administer the pneumococcal vaccine as indicated by the current Centers for Disease Control and Prevention (CDC) guidelines for three residents (Residents #1, #38 and #47), in a review of 17 sampled residents. The facility census was 54. Review of the CDC's Pneumococcal Vaccine Timing for Adults, updated October 2024, showed the following:-For adults 50 years or older who have never received any pneumococcal vaccine or whose previous vaccination history is unknown, administer PCV15, PCV20, or PCV21; -If PCV15 is administered, administer a dose of PPSV23 at least one year after the dose of PCV15. If the PPSV23 is not available, the PCV20 or PCV21 may be used;-If PCV20 or PCV21 is administered, regardless of which vaccine is used, their pneumococcal vaccinations are complete;-For adults 50 years or older who received the PPSV23 only at any age, administer the PCV15, PCV20 or the PCV 21 at least one year after the PPSV23 was administered;-For adults 50 years or older who received the PCV13 only at any age, administer the PCV20 or PCV21 at least one year after the PCV13 was administered;-For adults 50 years or older who received the PCV13 at any age and the PPSV23 when less than [AGE] years of age, administer the PCV20 or PCV21 after at least five years after the last pneumococcal vaccine dose;-For adults 65 years or older who received the PCV13 at any age and the PPSV23 at 65 years or older, the individual and their vaccination provider may choose to administer the PCV20 or PCV21 after at least five years after the last pneumococcal vaccine dose. (Refer to the CDC's Shared Clinical Decision-Making PCV20 or PVC21 Vaccination for Adults 65 Years or Older for additional information on clinical decision making.) 1. Review of the Resident #38's undated face sheet showed the following:-He/She admitted to the facility on [DATE];-He/She was over age [AGE];-He/She had a diagnosis of diabetes mellitus (medical condition characterized by abnormally high blood sugar levels) and asthma (chronic respiratory illness);-He/She had a representative responsible for making medical decisions. Review of the resident's preventative health documentation, located in his/her electronic health record (EHR), showed the following:-No documentation the resident received pneumococcal vaccinations;-No documentation the resident was offered or refused any pneumococcal vaccinations.(The resident was not up to date on the pneumococcal vaccination per CDC recommendations.) Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 05/24/25, showed the following:-His/Her cognition was severely impaired;-The resident's pneumococcal vaccinations were up to date. During an interview on 08/21/25 at 12:30 P.M., the resident's representative said he/she thought resident was up to date with pneumococcal vaccinations. He/She expected the resident to be up to date with all immunizations. 2. Review of the Resident 1's undated face sheet showed the following:-He/She was admitted to the facility on [DATE];-He/She was over the age of 65;-He/She had a diagnosis of diabetes mellitus;-He/She was his/her own person. Review of the resident's quarterly MDS, dated [DATE], showed the following:-His/Her cognition was intact;-The resident's pneumococcal vaccination was up to date. Review of the resident's preventative health documentation, located in his/her EHR, on 8/20/25 showed the following: -The resident received the pneumonia vaccination of unknown type on 12/31/19;-No documentation the resident was offered, received, or refused any additional pneumococcal vaccine.(The resident was not up to date on the pneumococcal vaccination per CDC recommendations.) During an interview on 08/21/25 at 12:40 P.M., the resident said he/she was not sure if he/she was up to date with the pneumonia vaccination. No one from the facility had offered him/her the pneumonia vaccination. He/she would take the pneumonia vaccination if offered. 3. Review of Resident #47's undated face sheet showed the following:-He/She admitted to the facility on [DATE];-He/She was over the age of 65;-Diagnoses included pneumonitis (inflamed lung tissue) due to inhalation of food and vomit, chronic obstructive pulmonary disease (COPD; obstructed airflow causing breathing difficulty), altered mental status and dementia (loss of memory and<br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | judgement);-He/She had a listed durable power of attorney (DPOA). Review of the resident's significant change MDS, dated [DATE], showed the following:-Moderately impaired cognition;-Pneumonia vaccine up to date. Review of the resident's preventive health record, located in the EHR, on 08/18/25 showed the following:-The resident received the PPSV23 (Pneumococcal Polysaccharide Vaccine 23-valent) out of the facility on 11/30/20;-No documentation the resident was offered, received, or refused any additional pneumococcal vaccines.(The resident was not up to date on the pneumococcal vaccination per CDC recommendations.) During an interview on 08/21/25 at 12:40 P.M., the resident's DPOA said he/she expected staff to offer any available vaccinations and wanted the resident to have them as needed. 4. During an interview on 08/20/25 at 11:30 A.M., the Director of Nursing said the facility did not track residents' pneumonia vaccination status. The current MDS Coordinator checked vaccination history for the new residents who are admitted . During an interview on 08/20/25 at 11:15 A.M., the MDS Coordinator said the following:-The nurse who had been tracking the residents' vaccinations quit a few months ago; -Upon a resident's admission, she assessed for vaccination history, including pneumococcal vaccinations, to see if vaccinations were up to date; -If resident and/or resident representative were unaware of the resident's vaccination history, the facility contacted the resident's primary care physician (PCP) for further instruction and orders. During an interview on 08/21/25 at 3:30 P.M., the Administrator said she expected all residents to be up to date with all immunizations, including the pneumococcal vaccination, per the CDC guidelines. |

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| F 0567<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to manage his or her financial affairs.<br><br>Based on interview and record review, the facility failed to implement policies and procedures to ensure residents' trust accounts were not allowed to go into a negative balance which affected one resident (Resident #40), in a review of seven sampled residents for which the facility maintained accounts. The facility census was 54. Review of the undated facility policy, Management of Residents' Personal Funds, showed the following:-The resident may have the facility hold, safeguard, and manage his or her personal funds;-Should the facility manage the resident's funds, the facility acts as a fiduciary of the resident funds and holds, safeguards, manages and accounts for the personal funds of the resident;-Inquiries concerning the facility's management of resident funds are referred to the administrator or to the business office. 1. Review of petty cash vouchers for the month of March, showed Resident #40 was allowed to obtain cash on the following dates:-On 03/07/25, the resident signed a facility petty cash voucher for $25.00 cash;-On 03/25/25, the resident signed a facility petty cash voucher for $30.00 cash;-On 03/28/25, the resident signed a facility petty cash voucher for $50.00 cash;-The sum of the resident's petty cash vouchers for the month of March was $105.00. Review of the facility-maintained Resident Trust Fund Statement, dated 04/01/25 through 04/30/25 showed the following: -On 04/01/25, the resident's beginning balance was $100.00;-On 04/06/25, check #2769 was taken out of the resident fund account and transferred to the facility account for $105.00 to replace the petty cash the resident had withdrawn for the month of March;-On 04/06/25, the resident's resident trust balance was -$5.00.-On 04/18/25, receipt of $80.00 cash from family was deposited into the residents' trust fund account. Review of petty cash vouchers for the month of April, showed Resident #40 was allowed to obtain cash on the following dates:-On 04/22/25, the resident signed a facility petty cash voucher for $30.00 cash;-On 04/28/25, the resident signed a facility petty cash voucher for $50.00 cash;-The sum of the resident's petty cash vouchers for the month of April was $80.00. Review of the facility-maintained Resident Trust Fund Statement, dated 04/01/25 through 04/30/25 showed the following: -On 04/30/25 interest distribution of $0.01 was deposited into the residents' trust fund account;-On 04/30/25 the resident's ending balance was $75.01. Review of petty cash vouchers for the month of May showed Resident #40 was allowed to obtain cash on the following dates:-On 05/01/25, the resident signed a facility petty cash voucher for $40.00 cash;-On 05/05/25, the resident signed a facility petty cash voucher for $35.00 cash;-The sum of the resident's petty cash vouchers for the month of May was $75.00. Review of the facility-maintained Resident Trust Fund Statement, dated 05/01/2025 through 05/30/25 showed the following:-On 05/01/25, the resident's beginning balance was $75.01;-On 05/07/25, check #2882 was taken out of the resident fund trust account and transferred to the facility account for $80.00 to replace the petty cash the resident had withdrawn for the month of April;-On 05/07/25 the resident's resident trust balance was -$4.99. Review of the facility-maintained Resident Trust Fund Statement, dated 06/01/25 through 06/30/25 showed the following:-On 06/01/25, the resident's beginning balance was -$4.99;-On 06/09/25, check #2885 was taken out of the resident fund trust account and transferred to the facility account for $75.00 to replace the petty cash the resident had withdrawn for the month of May;-On 06/09/25, the resident's resident trust balance was -$79.99. Review of the facility-maintained Resident Trust Fund Statement, dated 07/01/25 through 07/31/25 showed the following:-On 07/01/25 the resident's beginning balance was -$79.99;-On 07/31/25 the resident's ending balance was -$79.99. During an interview on 08/21/25 at 8:45 A.M., Resident #40 said the following:-His/Her spouse provided money for his/her resident trust account;-He/She always gets his/her money from the receptionist;-He/She was told by the receptionist about six months ago, he/she did not have any money. During an interview on 08/20/25 at 12:07 P.M., the receptionist said the following:-If a resident asked for cash, she would have the resident sign a petty cash voucher and give them money from the facility's petty cash drawer;-She always checked a resident's account balance on the computer before giving a resident cash;-The computer system never showed Resident<br>(continued on next page) |

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| F 0567<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | #40 was in debt;-She would not have given Resident #40 any money if he/she was in debt;-She balances the petty cash box monthly and gives the petty cash vouchers to the Business Office Manager (BOM) for reimbursement;-She did not check the slips in her petty cash drawer before giving Resident #40 money;-There was no accurate fund balance during the month until the slips are given to the BOM for reimbursement. During an interview on 08/20/25 at 10:07 A.M., 12:01 P.M. and 12:35 P.M., the BOM said the following:-If she was not available, the receptionist provided money for residents out of the facility petty cash drawer;-A resident would go to the receptionist and sign a petty cash voucher to obtain money;-The receptionist kept the petty cash vouchers in the facility's petty cash drawer for one month;-The receptionist turned the petty cash vouchers in to her for repayment one time per month;-There were two petty cash drawers at the facility - one is at the receptionist's desk and is the facility petty cash and the other is in the business office, and it is the resident trust petty cash drawer;-She was the only person who was authorized to get into the resident trust petty cash drawer; -The receptionist was the only person who had access to the facility's petty cash drawer;-She would only know the accurate balance after she reimbursed the cash vouchers the receptionist brought her one time a month; (this is when the computer would show the resident's actual balance);-The resident's spouse provided money for the resident's trust fund account;-The resident's spouse was in another state and had not sent money for the resident's trust fund account;-She had asked the resident to stay under $100.00 in debt;-The resident's spouse was told the resident was in debt and needed money for the resident's trust fund account, but the resident's spouse had not sent any money for the resident fund trust account;-She did not think the resident's debt in the resident fund trust account affected any of the other residents with funds in the resident trust fund account. During an interview on 08/21/25 at 10:40 A.M., the Administrator said the following:-When a resident wanted cash, they would go to the receptionist and ask for money and the receptionist will give them money;-She did not think the receptionist had access to check a resident's resident trust fund balance before giving the resident money;-The receptionist keeps the petty cash receipts in her drawer and gives them to the BOM one time a month for reimbursement;-The BOM would not have known how much money a resident was given out of the petty cash drawer; she was not updating the balances timely with every petty cash withdrawal because the receptionist was giving money, keeping a voucher in the petty cash drawer and only turning them in once a month; -Residents should not be able to withdraw money that was not available in their trust account;-Resident #40's spouse had not been able to send money for his/her trust account;-She was not aware Resident #40 went into debt in April 2025;-She did not consider Resident #40 was using other resident's money from the trust fund if he/she had a negative balance;-If all the residents wanted to withdraw their money today from the resident trust account there would not be enough money to cover all the accounts;-There should be a better system for cash disbursement to the residents. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation, interview and record review, the facility failed to follow physician orders for one resident (Resident #51), in a review of 17 sampled residents, when staff did not compare the pharmacy label of a medication card against the medication administration record and administered the wrong dose of medication to the resident. Staff also failed to follow manufacturer's recommendation and professional standards when administering eye drops for one resident (Resident #2), when pressure was not applied and held to the inside corner of the eye (inner canthus), after administration. The facility census was 54. Review of the facility's policy, Administering Medications, revised April 2019, showed the following:-Medications are administered in a safe and timely manner, and as prescribed;-Medications are administered in accordance with prescribed orders, including any required time frame;-The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication;-As required or indicated for a medication, the individual administering the medication records the dosage in the resident's medical record. Review of the undated facility policy, Procedure: Prepare, Administer, Report and Record Ophthalmic (Eye) Medications, showed the following:-The purpose of this procedure is to provide guidelines for instillation of eye drops to treat medical conditions, eye infections and dry eyes;-Hold lower eyelid away from the eye to form a pouch;- For eye drops instill drop into the pouch, never directly onto the center of the eyeball;- With a finger, apply pressure to the inside corner of the eye (inner canthus) for one minute;- Instruct resident to close eye gently and keep eyes closed for a few minutes;- Blot excess medication from cheek with tissue. 1. Review of Resident #51's Physician Order Report, dated 07/01/25 through 07/31/2025, showed the following:-Diagnosis of major depressive disorder (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities);-Fluoxetine (medication for major depressive disorder), 20 milligram (mg) capsule, one capsule daily, by mouth, discontinued 07/24/2025;-Fluoxetine 20 mg capsule, one capsule daily, by mouth, start date 07/24/25 end date 07/25/25. Review of pharmacy records showed on 07/24/25, two fluoxetine 20 mg capsules and 15 fluoxetine 10 mg capsules were delivered to the facility. Review of the resident's MAR, dated 07/24/25 thru 07/25/25, showed the following:-07/24/25, staff documented fluoxetine 20 mg was administered;-07/25/25, staff documented fluoxetine 20 mg was administered. Review of the resident's Physician Order Report, dated 07/01/25 through 07/31/2025, showed an order for fluoxetine 10 mg capsule, one capsule daily, by mouth, start date 07/26/25. Review of the resident's MAR, dated 07/26/25 thru 07/31/25, showed staff documented fluoxetine 10 mg was administered. Review of the resident's Medication Administration Record (MAR), dated 08/01/25 through 08/19/25, showed an order for fluoxetine capsule, 10 mg, administer one capsule by mouth, once a day, start date 07/26/25. Review of pharmacy records showed on 08/11/25, 15 fluoxetine 20 mg capsules were delivered to the facility. Observation on 08/19/25 at 8:55 A.M., during medication administration, showed the following:-Registered Nurse (RN) C pulled a fluoxetine 20 mg medication card from the 100-hall medication cart, labeled for the resident; -He/She did not administer the medication. During an interview on 08/19/25 at 8:55 A.M. and 4:48 P.M., RN C said the following:-The fluoxetine 20 mg capsule card should not have been in the medication cart;-The medication was the incorrect dose;-The resident did not have a fluoxetine 10 mg medication card in the medication cart;-He/She did not administer fluoxetine 20 mg because it was the incorrect dose;-Several capsules had been taken out of the medication card labeled fluoxetine 20 mg;-The resident had been receiving the wrong dose of medication;-The staff member who put in the new fluoxetine 10 mg medication order would have been responsible for pulling the discontinued fluoxetine 20 mg medication card from the medication cart. During a phone interview on 08/27/25, Licensed Practical Nurse (LPN) D said the following:-On 07/24/25 he/she had transcribed the physician's order to decrease the resident's fluoxetine from 20<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | mg to 10 mg;-He/She had reported to the oncoming nurse the medication order had been sent;-He/She did not remove the fluoxetine 20 mg medication card from the medication cart because he/she thought it would take some extra time for the medication to be sent from the pharmacy;-Normally any medication which was discontinued would be pulled from the medication cart and any remaining medication in the card would be destroyed. Review of the resident's pharmacy profile, dated 07/01/2025 thru 08/28/25, showed the following:-Pharmacy profile provided via email from the dispensing pharmacy;-On 08/11/25, fifteen fluoxetine 20 mg were dispensed. Review of the resident's MAR, dated 08/01/25 thru 08/19/25, showed the following:-Staff documented the resident's fluoxetine 10 mg dose was administered on 08/12/25, 08/13/25, 08/14/25, 08/15/25, 08/16/25, 08/17/25 and 08/18/25 (a total of seven administrations);-Staff documented the resident's fluoxetine 10 mg dose was not administered on 08/19/25 because the medication was not available. During a phone interview on 08/27/25, LPN D said the following:-On 08/13/25 he/she administered one fluoxetine 20 mg (a green and white capsule) to the resident and documented he/she gave one fluoxetine 10 mg capsule on the resident's MAR; it was a mistake;-The best practice when administering medications to a resident is to compare the medication card to the MAR before administering the medication to the resident. During an interview on 08/19/25 at 8:55 A.M. and 4:48 P.M., RN C said the following:-He/She administered fluoxetine 20 mg, one capsule, on 08/14/25;-On 08/14/25 he/she had documented on the resident's MAR administration of fluoxetine 10 mg one capsule at 8:00 A.M.;-He/She had administered fluoxetine 20 mg capsule on 08/14/25 because he/she was in the habit of just checking the medication name and not checking the medication dosage to see if it matched the MAR;-It was best practice to check the medication order with the medication card and the dose of the medication before administering any medication. Review of the facility's Individual Resident's Disposition Record, dated 08/20/25, showed the following:-A label had been affixed under Resident column;-The label showed the prescription number, Resident #51's name, the medication, and the date the medication was dispensed;-The prescription number on the label showed 7362701;-The medication listed on the label showed fluoxetine 20 mg;-The dispensed date listed on the label showed 08/11/2025;-Seven doses of fluoxetine 20 mg had been administered from the medication card. During a telephone interview on 08/28/25 at 9:01 A.M., the pharmacist said the following:-On 08/11/25, the resident was dispensed fluoxetine 20 mg;-It was a mistake; -The pharmacy had been sent the correct order, but did not discontinue the fluoxetine 20 mg prescription and the 20 mg prescription was sent to the facility by mistake;-On 8/19/25 the charge nurse called the pharmacy and the pharmacy had to manually go into the residents record and discontinue the 20 mg prescription as it was still in their system;-The facility called on 08/19/25 to inform the pharmacy of the mistake. During an interview on 08/21/25 at 12:58 P.M. and 08/28/25 at 9:24 A.M., the Director of Nursing (DON) said the following:-Staff should follow physician orders;-Residents should receive the proper dose of medication;-Staff are supposed to transcribe new medication orders and send the order to the pharmacy; -Staff who transcribe the medication order should pull the discontinued medication from the medication cart;-Staff who transcribe a new medication order was responsible for following up to ensure the new medication was on the medication cart;-The discontinued medication card should be pulled from the cart and the medication destroyed;-Prescriptions are electronically sent to the pharmacy;-When medications are delivered from the pharmacy, the evening or night shift Certified Medication Technician (CMT) or the nurse checks the medications delivered with the list the pharmacy sends to ensure they match;-Staff then put the medication on the medication cart or in the medication storage room;-Staff administering medication should ensure a resident receives the correct dosage;-Staff should aways check the resident, the medication, the dose, and the route before any medication was administered;-Staff should not give a fluoxetine 20 mg capsule and document on the MAR fluoxetine 10 mg capsule was given. During an interview on 08/21/25 at 2:39 P.M. and 08/27/25 at 4:47 P.M., the Administrator said the following:-All discontinued medications are destroyed at the facility;-Staff should follow physician orders;-A<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265574 | A. Building<br>B. Wing | 08/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Monroe City Manor Care Center | 1010 Highway 24 & 36 East<br>Monroe City, MO 63456 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident should receive their ordered dose of medication;-Staff should not give 20 mg of a medication and chart 10 mg was given on the MAR. 2. Review of the Combigan (brimonidine tartrate and timolol maleate 0.2-0.5 percent (%) ophthalmic solution - medication used to decreases elevated intraocular (inside eye) pressure) website showed the following:- Instructions for applying eye drops:-Gently close your eyes and lightly press on the inside corners of your eyes;- Carefully blot away any excess liquid that may be on your skin. Review of Resident #2's face sheet showed diagnosis of ocular hypertension (a condition where the intraocular pressure (IOP) (pressure inside the eye) is higher than normal), bilateral (both eyes). Review of the resident's Physician Order Summary, dated August 2025, showed an order for Combigan 0.2-0.5 % drops, one drop in both eyes, administer two times a day. Observation on 08/19/25 at 8:59 A.M., during medication administration, showed the following:-RN C took brimonidine tartrate and timolol maleate 0.2-0.5% ophthalmic solution out of the medication cart;-RN C used hand sanitizer and applied gloves;-RN C gave the resident a Kleenex;-RN C pulled down the resident's lower right eye lid and instilled one drop of brimonidine tartrate and timolol maleate 0.2-0.5% ophthalmic solution into the eye lid pocket;-RN C did not apply pressure to the inside corner of the eye for one minute after instilling the eye drop;-RN C did not instruct the resident to close his/her eye or to keep his/her eyes closed for a few minutes;-RN C pulled down the resident's lower left eye lid and instilled one drop of brimonidine tartrate and timolol maleate 0.2-0.5% ophthalmic solution into the eye lid pocket;-RN C did not apply pressure to the inside corner of the eye for one minute after instilling the eye drop;-RN C did not instruct the resident to close his/her eye or to keep his/her eyes closed for a few minutes;-Liquid ran under the resident's right and left eye;-The resident used the Kleenex to wipe the liquid from under his/her eyes. During an interview on 08/19/25 at 9:55 A.M., RN C said the following:-When administering eye drops, pressure should be held on the corner of the eyelid by the nose for five minutes;-He/She started to tell the resident to hold pressure, but thought it was a missed opportunity because the resident was already wiping his/her eyes with a tissue;-He/She should have educated the resident on the proper administration of the eye drops. During an interview on 08/21/25 at 12:58 P.M., the DON said staff should hold pressure on the corner of the eyelid by the nose for one-two minutes after administering eye drops. During an interview on 08/21/25 at 2:39 P.M., the Administrator said staff should administer all medications properly. |