

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2025
NAME OF PROVIDER OR SUPPLIER  Marshfield Care Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  800 South White Oak Marshfield, MO 65706	

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 - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.  (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interview, the facility failed to provide pharmacy services to meet the needs of each resident when the facility failed to have ordered medications available for staff administration and failed to notify the physician of the unavailable medications resulting in three residents (Resident #1, #2, and #3) not receiving medications as ordered. The facility census was 49. Review of the facility's policy titled Medication Administration, revised 05/07/25, showed medications are administered as ordered by the physician and in accordance with professional standards of practice. 1. Review of Resident #1's face sheet (brief resident profile sheet) showed the following information:-admission date of 09/05/25;-Diagnoses included multiple sclerosis (a chronic, autoimmune disease that affects the central nervous system), cardiac pacemaker (a small, implantable medical device that helps regulate the heart's rhythm by sending electrical impulses to the heart muscle), hypothyroidism (the thyroid gland doesn't make and release enough hormone into the bloodstream), and restless legs syndrome (a neurological disorder characterized by an irresistible urge to move the legs, often accompanied by uncomfortable sensations like tingling or crawling). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 09/08/25, showed the resident had no cognitive impairment. Review of the resident's care plan, reviewed on 09/08/25, showed staff to administer medications as ordered. Review of the resident's current physician orders showed the following information:-An order, dated 09/06/25, for pantoprazole sodium (used for ulcer prevention) oral tablet delayed release 40 milligram (mg). Start date of 09/06/25 at 7:30 A.M.;-An order, dated 09/06/25, for venlafaxine HCl (an antidepressant) ER oral tablet extended release 24-hour 75 mg. Start date of 09/06/25 at 7:30 A.M.;-An order, dated 09/06/25, for mirabegron (an antispasmodic) ER oral tablet extended release 24-hour 50 mg. Start date 09/06/25 at 8:00 A.M.;-An order, dated 09/06/25, for ropinirole HCl (an anti-parkinson medication) 2 mg, at bedtime. Start date of 09/06/25 at 8:00 P.M. Review of the resident's September 2025 Medication Administration Record (MAR) showed the following information:-On 09/06/25, at 7:30 A.M., staff documented the doses of pantoprazole and venlafaxine as Not Administered: Drug not available;-On 09/06/25, at 8:00 A.M., staff documented the dose of mirabegron as Not Administered: Drug not available;-On 09/06/25, at 8:00 P.M., staff documented the dose of ropinirole as Not Administered: Drug not available;-On 09/07/25, at 7:30 A.M., staff documented the dose of pantoprazole and venlafaxine as Not Administered: Drug not available;-On 09/07/25, at 8:00 P.M., staff documented the dose of ropinirole as Not Administered: Drug not available. Review of the resident's September 2025 Progress Notes showed staff did not document physician notification of the missed doses of pantoprazole, venlafaxine, mirabegron and ropinirole. During an interview on 09/10/25, at 2:30 P.M., the resident said he/she had not refused any medications. He/she admitted to the facility on [DATE], at 9:00 P.M. Because he/she did not receive his/her medications for a couple of days, it will take his/her body weeks to get back to feeling normal. His/her body was used to the prescribed medications and that he/she had been on those medications for a while, and they were working well for him/her. If he/she would have known prior to coming to the facility that they would not have her medication, he/she would have gone to another facility. During an interview on 09/10/25, at 11:45 A.M., Licensed Practical Nurse (LPN) A said the residents came in late in the day and on a weekend, so their medications would not have been available until Monday. During an interview on 09/10/25, at 2:45 P.M., LPN D said he/she and the Director of Nursing (DON) notified the physician of the resident's admission and told the physician that they did not have the medications. The physician was not happy they accepted the resident knowing that we did not have the medications. The physician gave no other orders. During an interview on 09/10/25, at 12:00 P.M., the Assistant Director of Nursing (ADON) said he/she did not realize the resident did not receive their medications. During an interview on 09/10/25, at 3:30 P.M., the Director of Nursing (DON) said the resident admitted to the facility with an order for ropinirole 1 mg every morning and ropinirole 2 mg every night. The facility does not keep that medication in the e-kit so they had to wait for the pharmacy to bring the medication. He/she called the physician and reviewed the medication list for the resident. The physician was upset that the facility accepted the resident knowing that they could not get their medications. No other orders were received during the phone conversation. During an interview on 09/10/25, at 5:10 P.M., the Medical Director said he did not know about the resident not receiving their medications until 09/09/25. Staff did not notify him. 2. Review of Resident #2's face sheet showed the following information:-admission date of 09/05/25;-Diagnoses included</p>		