

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265674	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER St Francois Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1180 Old Jackson Road Farmington, MO 63640	
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>32751</p> <p>Based on interview and record review, the facility failed to follow physician's orders regarding medication for one resident (Resident #1) out of three sampled residents. The census was 80.</p> <p>Review of the facility's policy titled Medication Administration Guidelines dated March, 2015, showed:</p> <ul style="list-style-type: none"> - It is the purpose of this facility that the residents receive their medications on a timely basis and in accordance with established policies. Drug administration shall be delivered as an act in which an authorized person, in accordance with all laws and regulations governing such acts, gives a single dose of a prescribed drug or biological to a resident. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident and promptly recording the information. <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> - Date of admission 10/31/24; - Diagnoses of paranoid schizophrenia (a term for a chronic mental illness that can cause people to lose touch with reality causing delusions, hallucinations and paranoia), insomnia, and anxiety. <p>Review of the resident's November 2024 Physician's Order Sheet (POS) showed:</p> <ul style="list-style-type: none"> - An order for clonazepam (a drug used to produce a calming effect on the brain and nerves) 0.5 milligrams (mg) to be administered four times daily starting 9/18/2024 <p>Review of the resident's Preadmission Screening and Resident Review (PASRR) a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis to ensure appropriate placement) dated 8/10/2020, showed:</p> <ul style="list-style-type: none"> - Behaviors consisting of bizarre delusions and paranoia; - The resident has a history of aggression and threatening behaviors. <p>Review of the resident's Medication Administration Record (MAR) for November 2024 showed:</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265674
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - On 11/12/2024 the resident missed two doses of clonazepam 0.5 mg; - On 11/13/2024 the resident missed three doses of the clonazepam 0.5 mg; - On 11/15/2024 the resident missed two doses of the clonazepam 0.5 mg; - On 11/16/2024 the resident missed four doses of the clonazepam 0.5 mg; - On 11/17/2024 the resident missed four doses of the clonazepam 0.5 mg; - On 11/18/2024 the resident missed three doses of the clonazepam 0.5 mg; - The resident missed 18 doses out of 28 opportunities. <p>Review of the resident's progress notes showed:</p> <ul style="list-style-type: none"> - On 11/15/2024, the resident informed the nurse he/she was feeling scared that someone was going to kill him/her and requested medication; - On 11/18/2024 the resident assaulted another resident by striking the resident in the mouth, staff noted the resident had not been receiving all of his/her medications; - On 11/18/2024 staff notified the facility Psychiatric Nurse Practitioner (PNP) regarding the clonazepam 0.5 mg. He told the facility he had ordered it on 11/15/2024 and will call the pharmacy to check. The pharmacy said they had lost the request for the medication but had just found it. <p>During an interview on 11/26/2024 at 11:45 A.M., the Director of Nurses (DON) said on 11/18/2024 she became aware that the resident had been out of clonazepam 0.5 mg but did not know for how long. She talked with multiple staff and found that Licensed Practical Nurse (LPN) A had discovered the resident was out of the medication on 11/15/2024 and called the PNP to find out why the medications had not been ordered. The PNP told the LPN A that he had ordered them before 11/15/2024 and was not sure what had happened. The PNP called LPN A and said the pharmacy had lost the order but found it when he called them and would fill it on 11/18/2024. The DON said the medications came on 11/18/2024 for the night dose. She said they currently have no procedure in place for ordering and following through on medications. She said she is working on a system to put in place. She did not know who had originally called the PNP to order the medications. She said when medications come in, whatever staff is available checks them in. There is no system to make sure a medication that did not come in would be caught and corrected. She said she would have expected staff to inform her when the resident ran out of the medication. She believes that the days where the resident did get one or two doses the medication was taken from the emergency medication kit, but they do not document who the medications are given to when they are taken out.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/26/2024 at 1:00 P.M., LPN A said a call was made to the PNP when it was discovered the resident had no clonazepam 0.5 mg. A staff member had informed him/her around 11/12/2024 that the medication was low. The order had been placed at that time. A few days later a Certified Medication Technician (CMT) B told him/her that they had been using medications from the emergency kit but there was no more. He/she then called the PNP to confirm if he had ordered the medication. He/she said the medications typically come in on evening shift. If they were ordered on day shift, no one would even know to look for them on evening shift. He/she had no idea until 11/18/2024 that the medications had not come in. He/she said they have no system in place for ordering or checking medications in. They have in the past just communicated verbally when a resident needed more medications.</p> <p>During an interview on 11/26/2024 at 1:20 P.M. CMT B said that he/she had noticed the resident was out of clonazepam 0.5 mg and the emergency kit was running low and informed LPN A. He/she said the resident was given medications from the emergency kit on his/her shift on 11/12/2024 and 11/13/2024. He/she said the CMTs have to get a nurse to assist with getting the medications from the emergency kit. He/she did inform LPN A when the emergency kit was out of the medication.</p> <p>During an interview on 11/26/2024 at 2:00 P.M., PNP said he had ordered the medications when the staff first called him. He was traveling on 11/18/2024 and they called him saying the resident had no medications. He said he contacted the pharmacy and they told him they had never received an order. He told them he had sent the order and would send them a copy of the fax when he got to the office. They called him back and said they had found it and would fill it and send by evening on 11/18/2024.</p> <p>During an interview on 11/26/2024 at 4:00 P.M., the Administrator (ADM) said she would expect the nurse to notify the DON when a resident is low on medications before they run out. She said she had not been aware the resident had ran out of the medication.</p> <p>MO00245318</p>		