STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265674	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francois Manor	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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 49152 Based on observation, interview, and record review the facility failed to provide a privacy curtain to maintain privacy for two residents (Resident #3 and #10) out of 18 sampled residents. The facility census was 77. 1. Observation on 06/10/24 at 11:15 A.M., showed: - Resident #3 lay in his/her bed; - Resident #10 sat on his/her bed and listened to music; - No privacy curtain between the beds. 2. Observation on 06/11/24 at 9:03 A.M. showed: - Resident #3 lay in his/her bed and folded clothes; - Resident #10 opened the bedroom door, entered the room, and sat on his/her bed; - No privacy curtain between the beds. During an interview on 06/11/24 at 9:03 A.M., Resident # 3 said he/she wanted more privacy. He/She liked the roommate but did not need him/her knowing everything he/she did at all the time. He/She was in a wheelchair and did not have enough room in the bathroom to change with privacy so he/she had to change in front of the roommate. During an interview on 06/11/24 at 9:06 A.M., Resident #10 said he/she had no privacy and struggled to sleep because he/she could see the roommate's TV on at night since there was no privacy curtain between the beds. During an interview on 06/13/24 at 9:10 A.M., Housekeeper A said housekeeping was not responsible for putting up the privacy curtains. He/She didn't know why Resident #3 and Resident #10 didn't have privacy curtains hung in their room. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/24 at 9:23 A.M., the Maintenance director said he/she was not responsible for putting up or taking down the privacy curtains. If there was a problem where something was broken concerning the curtain or hooks supporting the curtain, then he/she would take the privacy curtain down, fix the problem, and hang it back up. He/She didn't know why Resident #3 and Resident #10 didn't have privacy curtains hung in their room. During an interview on 06/13/24 at 3:00 P.M., the Administrator expected the residents to have their privacy protected.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49152 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 77. Review of facility's policy titled, Deep Clean Schedule, undated, showed: - A deep clean should be performed every four-six weeks; - The housekeeping supervisor must develop a deep clean schedule. 1. Observations of room [ROOM NUMBER] on 06/10/24 at 10:25 A.M., and 06/13/24 at 11:12 A.M., showed a three inch (in.) circular hole next to the bathroom door. 2. Observation of room [ROOM NUMBER] on 06/10/24 at 11:00 A.M., showed: - A three inch hole in ceiling above the bed next to the window; - No door on the closet; - The dresser missing the top drawer; - The room walls near the bathroom with a brown film and small brown dots; - A gray/black fuzzy substance covered the bathroom vent. 3. Observations of room [ROOM NUMBER] on 06/10/24 at 11:15 A.M., and 06/13/24 at 11:13 A.M., showed: - No privacy curtain in the room between the beds; - A gray/black fuzzy substance covered the bathroom vent. During an interview on 06/10/24 at 11:10 A.M., the residents in rooms [ROOM NUMBERS] said no one cleaned the walls and the bathroom vents. Housekeeping came in once a day and did the trash, swept the floor, and wiped down the sink and the bathroom. 4. Observations of room [ROOM NUMBER] on 06/11/24 at 9:02 A.M., showed: - The cove base peeled off on the corner beside the closet, the corner behind the door, and no cove base under the air conditioner unit; - A mini tabletop refrigerator door stuck when opening; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Overbed table rusted with black debris built up on the feet and legs; - The floor under the overbed table beside the recliner covered with orange/red sticky substance; - The recliner with a black build up on the feet; - Area under the air conditioner unit with pieces of brown debris in varying sizes; - A brown substance splattered on 3/4th of the bathroom door and on the the walls on both sides of the door. During an interview on 06/11/24 at 9:02 A.M., the resident in room [ROOM NUMBER] said housekeeping only cleaned the floor in his/her room. He/She moved into the room a few months ago and is still going through their belongings. 5. Observation on 06/11/24 at 10:30 A.M. of room [ROOM NUMBER] showed the door did not open with ease and made black markings on the floor surface. During an interview on 06/11/24 at 10:30 A.M., the resident in room [ROOM NUMBER] said he/she wasn't sure how long the door to his/her room had been sticking and making black marks. He/She had notified staff of the problem with the door. 6. Observation on 06/13/24 at 11:30 A.M., of room [ROOM NUMBER] showed a night light fixture on the wall next to the room door without a cover and with an exposed empty light socket. During an interview on 06/13/24 at 11:30 A.M., the resident in room [ROOM NUMBER] said the night light in the room had not had a cover for as long as he/she had resided at the facility. During an interview on 6/13/24 at 9:00 A.M., Housekeeper A said daily cleaning included emptying the trash; checking toilet paper and paper towels; and cleaning the sinks, mirrors, vents, toilets, sweeping and mopping the floor. Items on the floor were cleaned under. Housekeeping did not help with organizing the resident's personal items. Housekeepers report environmental issues to their supervisor and then fill out a slip for maintenance. Housekeeping had been unable to get the sticky stain in room [ROOM NUMBER] off the floor. During an interview on 06/13/24 at 1:28 P.M., the Director of Nursing (DON) said staff were expected to put in the maintenance log of any environmental issues they found such as holes in the wall, base boards coming off, or a sticky floor that would not come clean. They had been trying to find a solution that would clean the sticky stain off the floor without stripping the floor. During an interview on 06/13/24 at 3:25 P.M., the Administrator said that she expects the building to be clean and in good repair. 49999

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on observation, interview, and record review, the facility failed to identify, assess and provide supportive interventions for six residents (Resident #3, #17, #27, #33, #41 and #51) with a diagnosis of post-traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of six sampled residents. The facility's census was 77. The facility did not provide a policy regarding PTSD. 1. Review of Resident #3's medical record showed: - An admitted [DATE]; - Diagnoses of post traumatic stress disorder PTSD, depression (a serious medical illness that negatively affects how you feel, the way you think, and how you act), schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations), major depressive disorder (MDD - long-term loss of pleasure or interest in life), anxiety (persistent worry and fear about everyday situations), bipolar (a mental disorder that causes unusual shifts in mood), and nightmare disorder (a pattern of repeated frightening and vivid dreams that cause significant distress or impaired functioning); - No documentation of a trauma assessment. Review of the resident's Physician Order Sheet (POS), dated 05/13/24 through 06/13/24, showed: - An order for amitriptyline (an antidepressant medication) 150 milligram (mg) tablet daily at bedtime for MDD, dated 05/09/24; - An order for prazosin (a blood pressure medication sometimes used for nightmares related to PTSD) 1 mg capsule at bedtime for nightmare disorder, dated 02/22/24; - An order for haloperidol (an antipsychotic medication) 10 mg tablet at bedtime for anxiety, dated 03/23/24, and an order for haloperidol 5 mg tablet at bedtime (for a 15 mg total dose) for anxiety, dated 04/27/24; - An order for quetiapine (an antipsychotic medication) 400 mg tablet at bedtime for schizophrenia, dated 05/24/24; - An order for Seroquel (an antipsychotic medication) extended release (XR) 200 mg tablet at bedtime for schizophrenia, dated 05/25/24. Review of the resident's Preadmission Screening and Resident Review (PASRR - a federal program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities), dated 08/12/20, showed: (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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident with PTSD; - Behaviors not specified; - Long term care placement for the resident's needs Review of the resident's care plan, revised 05/27/24, showed: - PTSD not addressed; - Did not address personalized triggers or interventions associated to the resident or triggers. 2. Review of Resident #17's medical record showed: - admitted [DATE]; - Diagnoses of schizophrenia, bipolar I disorder, generalized anxiety disorder, PTSD, personal history of sexual abuse, multiple personality disorder (a disorder characterized by the presence of two or more distinct personality states), intermittent explosive disorder (a disorder characterized by repeated, sudden bouts of impulsive aggressive, violent behavior or angry verbal outbursts), mild intellectual disability, borderline personality disorder (a mental disorder characterized by unstable moods, behavior, and relationships), and pseudobulbar affect disorder (inappropriate involuntary laughing and crying due to a nervous system disorder); - No documentation of a trauma assessment. Review of the resident's POS, dated 05/13/24- 06/13/24, showed: - An order for Nuedexta (a medication used to treat pseudobulbar affect disorder) 20-10 mg one capsule every 12 hours related to pseudobulbar affect, dated 07/30/18; - An order for clozapine (an antipsychotic medication) 50 mg two tablets two times a day related to schizophrenia, dated 12/08/22; - An order for Depakote Extended Release (an anticonvulsant medication) 500 mg four tablets at bedtime related to schizophrenia, dated 01/03/23; - An order for doxepin (an antidepressant medication)10 mg one capsule at bedtime related to generalized anxiety disorder, dated 08/16/23, and discontinued on 06/07/24; - An order for duloxetine delayed release (an antidepressant medication) 60 mg two capsules daily related to major depressive disorder, dated 03/01/24. Review of the resident's PASRR, dated 04/04/18, showed: - Resident with PTSD sexual abuse; (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Behaviors included anxiety, pacing, violent outburst when agitated, combativeness, impulsiveness, tearful, screams, poor judgement and decision making; - Long term care placement recommended for the resident's needs. Review of resident's care plan, revised 05/03/24, showed: - PTSD not addressed; - Did not address personalized triggers on interventions associated to the resident or triggers. During an interview on 06/13/24 at 1:00 P.M., Resident #17 said staff had not talked to him/her about his/her diagnosis of PTSD since admission. He/She had triggers and had been triggered since admission. 3. Review of Resident #27's medical record showed: - admitted [DATE]; - Diagnoses of PTSD, schizophrenia, bipolar disorder, nightmare disorder, anxiety disorder, borderline personality disorder, mild intellectual disabilities, and intermittent explosive disorder; - Review of the resident's trauma assessment, dated 01/05/24, showed resident triggers not addressed. Review of the resident's POS, dated June 2024, showed: - An order for Invega Sustenna (an antipsychotic medication) 234 mg /1.5 milliliters (ml) intramuscularly (IM) once a day on the 29th of the month related to schizophrenia, dated 04/27/24; - An order for Zoloft (an antidepressant medication) 100 mg two tablets once a day related to depression, dated 10/6/23. Review of the resident's PASRR, dated 08/23/23, showed: - Resident with PTSD; - Behaviors included frequent/continuous yelling, invades other's space, wandering, cursing/swearing, strike others unprovoked, lies purposefully, and verbalizations or crying out; - Long term care placement recommended for the resident's safety. Review of resident's care plan, revised 12/21/23, showed: - PTSD not addressed; - Did not address personalized triggers or interventions associated to the resident or triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of Resident #33's medical record showed: - admitted [DATE]; - Diagnoses of PTSD, schizophrenia, bipolar disorder, generalized anxiety disorder, narcissistic personality disorder (a disorder in which a person has an inflated sense of self-importance), nightmare disorder, and personal history of physical and sexual abuse in childhood. - No documentation of a trauma assessment. Review of the resident's POS, dated June 2024, showed: - An order for Invega Sustenna 234 mg/1.5 ml IM once a day on the 5th of the month related to schizophrenia, dated 05/12/23; - An order for Risperdal (an antipsychotic medication) 4 mg by mouth at bedtime related to schizophrenia, dated 06/07/24; - An order for Wellbutrin (an antidepressant medication) suspended release (SR) 150 mg by mouth once a day related to generalized anxiety disorder, dated 06/07/24. Review of the resident's PASRR, dated 10/12/16, showed: - Resident with PTSD; - Behaviors included alcohol/drug use; - Long term care placement recommended for the resident's safety. Review of the resident's care plan, revised 05/28/24, showed: - PTSD was not addressed; - Did not address personalized triggers or interventions associated to the resident or triggers. 5. Review of Resident #41's medical record showed: - admitted [DATE]: - Diagnoses of PTSD, schizoaffective disorder, generalized anxiety disorder, and borderline intellectual functioning; - No documentation of a trauma assessment. Review of the resident's POS, dated June 2024, showed: - An order for Zyprexa (an antipsychotic medication) 20 mg once a day related to schizoaffective disorder, dated 08/16/23; (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for Zoloft 200 mg once a day related to generalized anxiety disorder, dated 01/24/24; - An order for Cymbalta (an antidepressant medication) 60 mg once a day related to schizoaffective disorder, dated 05/24/24. Review of the resident's PASRR, dated 11/16/18, showed: - Resident with PTSD; - Behaviors include striking others and verbally threatening; - Long term care placement recommended for the resident's safety. Review of resident's care plan, revised 06/13/24, showed: - PTSD added to the problem list on 06/13/14; - Did not address personalized triggers or interventions associated to the resident's triggers. During an interview on 06/13/24 at 11:22 A.M., Resident #41 said, he/she had experienced triggers since living at the facility and the staff had not asked about triggers. 6. Review of Resident #51's medical record showed: - admitted [DATE]; - Diagnoses of PTSD, bipolar disorder, anxiety disorder, nightmare disorder, borderline intellectual functioning, and attention-deficit hyperactivity disorder (a chronic condition including attention difficulty, hyperactivity, and impulsiveness); - No documentation of a trauma assessment. Review of the resident's POS, dated June 2024, showed: - An order for Abilify (an antipsychotic medication) 5 mg by mouth once a day related to bipolar disorder, dated 06/03/24; - An order for amitriptyline (an antidepressant medication) 100 mg by mouth at bedtime related to bipolar disorder, dated 08/16/23; - An order for Risperdal 2 mg orally twice a day related to bipolar disorder, dated 06/02/23; - An order for Tegretol (an anticonvulsant medication) 200 mg three tablets twice a day related to bipolar disorder, dated 01/06/23. Review of the resident's PASRR, dated 10/12/16, showed: - Resident with PTSD; (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No behaviors listed; - Long term care placement recommended for the resident's needs. Review of the resident's care plan, revised 05/03/24, showed: - PTSD was not addressed; - Did not address personalized triggers or interventions associated to the resident or triggers. During an interview on 06/13/24 at 11:35 A.M., Certified Nurse's Assistant (CNA) B said he/she was not aware of where to locate a resident's interventions related to triggers. During an interview on 06/13/24 at 11:37 A.M., Registered Nurse (RN) C said a resident's diagnosis of PTSD and the associated triggers should be addressed on admission by Social Services, and the triggers should be addressed on the care plan. During an interview in 06/13/24 at 12:30 P.M., the interim Social Services Designee (SSD) said residents were assessed for a history of PTSD at admission and should be assessed at that time for triggers. During an interview on 06/13/24 at 12:30 A.M., the Director of Nursing (DON) said she would expect a resident with a diagnosis of PTSD to be assessed for triggers. During an interview on 06/13/24 at 12:30 P.M., the Administrator said she would expect a resident with a diagnosis of PTSD to be assessed for triggers. 47678 49999

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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** 49152 Based on observation, interview, and record review, the facility failed to implement procedures to ensure medications were accurately administered, documented, disposed of and reconciled for one resident (Resident #3) out of 18 sampled residents and for one resident (Resident #8) outside the sample. The facility census was 77. Review of the facility's policy titled, Medication Monitoring and Management, revised January 2018, showed: - A new medication order is evaluated for dose, route of administration, duration, monitoring in agreement with current clinical practice, guidelines, or manufacturer's specifications for use, a written diagnosis supports each medication, and the prescriber documents the clinical rationale for using a medication outside the stated guidelines; - The resident is evaluated before initiating, withdrawing, or withholding medications. Review of the facility's policy titled, Medication Storage in the Facility, revised January 2018, showed: - Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier; - Medication storage conditions are monitored on a quarterly basis by the consultant pharmacist or pharmacy designee and corrective action taken if problems are identified; - The nurse will check the expiration date of each medication before administering it; - Nursing staff should consult with the dispensing pharmacist for any questions related to medication expiration dates. 1. Review of Resident #3's Physician Order Sheet (POS), dated 05/13/24-06/13/24, showed: - An admitted [DATE]; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of post traumatic stress disorder (PTSD - a disorder where a person has difficulty recovering after experiencing or witnessing a terrifying event), gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), viral hepatitis (inflammation of the liver due to a viral infection), depression (a serious medical illness that negatively affects how you feel, the way you think, and how you act), schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations), major depressive disorder (MDD - long-term loss of pleasure or interest in life), anxiety (persistent worry and fear about everyday situations), bipolar (a mental disorder that causes unusual shifts in mood) disorder, and other disorders of urea (a nitrogen-containing substance normally cleared from the blood by the kidney into the urine) cycle metabolism (the body's way of converting toxic ammonia into urea); - An order for quetiapine (an antipsychotic medication) 400 milligram (mg) tablet at bedtime for schizophrenia , dated 05/24/24; - An order for Seroquel (an antipsychotic medication) extended release (XR) 200 mg tablet at bedtime for schizophrenia, dated 05/25/24; - An order for Xifaxin (an antibiotic) 550 mg tablet twice a day for other disorders of urea cycle metabolism, dated 05/25/24. Review of the resident's MAR, dated 05/14/24-06/13/24, showed: - Xifaxin 550 mg twice a day not administered on 06/10/24 morning dose, 06/11/24 morning and night dose, and 06/12/24 morning and night dose with five out of 40 doses missed; - Quetiapine 400 mg at bedtime not administered on 06/03/24 with one out of 31 doses missed; - Seroquel XR 200 mg at bedtime not administered on 06/04/24, 06/05/24, 06/06/24, 06/07/24, 06/10/24, 06/11/24, and 06/12/24 with seven out of 19 doses missed. During an interview on 06/10/24 at 11:00 A.M., Resident #3 said he/she had not received some of his/her medications for the last week. He/She needs the medications to go to sleep and not hallucinate. 2. Review of Resident #8's POS, dated 05/13/24-06/13/24, showed: - An admitted [DATE]; - Diagnosis of schizophrenia; - An order for medroxyprogesterone (a type of hormone) 10 mg tablet three times a day for other sexual dysfunction not due to a substance or known physiological condition, dated 02/19/24. Review of the resident's MAR, dated 05/14/24-06/13/24, showed medroxyprogesterone 10 mg three times a day not administered on 06/10/24 all three does, 06/11/24 all three doses, and 06/12/24 evening and night dose with seven out of 94 doses missed. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/12/24 at 1:30 P.M., Licensed Practical Nurse (LPN) I said Resident #3's Xifaxin was not in the facility due to it needed to be looked at by a physician for a refill. He/she did not know about Resident #8 being out of the medroxyprogesterone and Seroquel. During an interview on 06/12/24 at 3:00 P.M., Certified Medication Technician (CMT) E said the facility used a system to order medications and whatever was requested went directly to the pharmacy. If a resident was out of a medication, the staff could use the system's link or fax the order and the CMTs could request a refill for almost all medications. CMT E let the nurses know if something was wrong or was having trouble ordering something. The pharmacy came to the facility every day except Sundays. During an interview on 06/13/24 at 12:15 P.M., the Director of Nursing (DON) said if staff requested a medication and it did not come in, then staff should call the pharmacy to see what the problem was or how to resolve the issue. During an interview on 06/13/24 at 12:30 P.M., Pharmacist H said the facility could go through the system's link online to request a refill of a medication or fax it to the pharmacy. For Resident #3's quetiapine 400 mg, the facility requested a refill on 06/03/24. The pharmacy was out of the medication for a day or two. For Resident #3's Seroquel XR 200 mg, it was requested on 06/03/24, and the pharmacy put an inquiry that it was too soon to be filled as a 30 day supply was last filled on 05/24/24. If the medication was truly out and the facility let them know, the pharmacy would have filled the medication. For Resident #3's Xifaxin, the facility requested the medication be refilled on 05/24/24, and on 06/12/24. The medication was sent by the pharmacy the same day on both days it was requested. For Resident #8's medroxyprogesterone 10 mg three times a day, the facility requested the medication be refilled on 05/25/24, and 06/12/24. The medication was sent by the pharmacy the same day on both days it was requested. The facility failed to request refills of the medications the residents were out of or did not call about the inquiry on the medications that the pharmacy said was too soon to be filled. During an interview on 06/13/24 at 3:00 P.M., the DON and Administrator said they would expect medications to be ordered before a resident ran out of a medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265674	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francois Manor	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49152 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted practices. This had the potential to affect all residents. The facility census was 77. Review of the facility's policy titled, Medication Storage in the Facility, revised January 2018, showed: - Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier; - Outdated or deteriorated medications are immediately removed from the inventory, disposed of according to procedures for medication disposal, and reordered from pharmacy if a current order exists; - Medication storage conditions are monitored on a quarterly basis by the consultant pharmacist or pharmacy designee and corrective action taken if problems are identified; - The nurse will check the expiration date of each medication before administering it; - No expired medication will be administered to a resident; - Nursing staff should consult with the dispensing pharmacist for any questions related to medication expiration dates. Observation of the medication storage room on 06/12/24 at 10:20 A.M., showed: - Four unopened vials of diphenhydramine (an antihistamine) 50 milligram (mg)/ milliliters (ml) vial with an expiration date of 03/2024; - Six tablets of clindamycin (an antibiotic) 150 mg with an expiration date of 04/12/24; - One unopened bottle of nitroglycerin (treats/relieves chest pain) sublingual (under the tongue) tablet 0.4 mg tablets with an expiration date of 04/20/24. During an interview on 06/12/24 at 10:20 A.M., Licensed Practical Nurse (LPN) D said the pharmacy came to the facility on ce a month and looked at everything. The pharmacy staff had just looked at the medication rooms and the medication carts on 06/10/24. During an interview on 06/13/24 at 3:00 P.M., the Director of Nursing (DON) and the Administrator said they would expect the medication rooms and carts to be checked for expired medications at minimum monthly and ideally twice a month.