

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265801	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/07/2025
NAME OF PROVIDER OR SUPPLIER  Katy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Prospect Pilot Grove, MO 65276	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>37131</p> <p>Based on interview and record review, facility staff failed to notify one resident's (Resident #1) physician after a significant medication error. The facility census was 56.</p> <p>1. Review of the facility's Notification of Change policy, undated, showed staff are directed to promptly consult the resident's physician when there is a change requiring notification. This includes adverse drug reaction and potential to require physician intervention. These may include adverse consequences, acute condition and exacerbation of chronic condition. The primary physician will be notified regardless of whether the resident is receiving Hospice Services.</p> <p>2. Review of Resident #1's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/29/24, showed staff assessed the resident received opioid seven days of the seven day look back period.</p> <p>Review of the resident's Physician Order Sheet (POS), dated February 2025, showed a physician order for Fentanyl 25 micrograms (mcg)/per hour and change every 72 hours.</p> <p>Review of the resident's Medication Administration Record (MAR), dated 01/07/25 through 02/06/25, showed staff documented they placed the Fentanyl patch on 01/31/25 on the resident's left upper back.</p> <p>Review of the facility's controlled log, undated, showed staff documented they signed out and administered the resident's Fentanyl patch on 01/31/25. Review showed Licensed Practical Nurse (LPN) B signed out a Fentanyl patch on 02/01/25.</p> <p>Review of the resident's Progress Note, dated 02/03/25, showed LPN A documented resident observed on 2/3/25 with two Fentanyl patches with two different dates, hospice and family were made aware. Review showed the progress not did contain documentation staff notified the residents primary physician.</p> <p>During an interview on 02/06/25 at 11:26 A.M., LPN A said he/she found the two Fentanyl patches on the resident on 02/03/25. LPN A said one Fentanyl patch was dated 01/31/25 and the other Fentanyl patch was dated 02/01/25. LPN A said he/she notified the Director of Nursing (DON). LPN A said he/she did not notify the Medical Director.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265801	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/07/2025
NAME OF PROVIDER OR SUPPLIER  Katy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  205 Prospect Pilot Grove, MO 65276	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/06/25 at 11:52 A.M., the Medical Director said he/she was not notified about the resident getting an extra dose of Fentanyl. The Medical Director said he/she would want to be notified.</p> <p>During an interview on 02/06/25 at 1:20 P.M., the DON said he/she had been notified on 02/03/25 the resident received two doses of Fentanyl by LPN A. The DON said he/she would consider this a significant medication error. The DON said he/she did not notify the Medical Director of the medication error.</p> <p>MO00249068</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265801	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/07/2025
NAME OF PROVIDER OR SUPPLIER  Katy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Prospect Pilot Grove, MO 65276	
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37131</p> <p>Based on interview, and record review, facility staff failed to ensure one resident (Resident #1) remained free from significant medication errors, when facility staff administered double the prescribed dosage of Fentanyl to the resident. The census was 56.</p> <p>1. Review of the facility's Medication Administration policy, undated, showed staff are directed as follows:</p> <ul style="list-style-type: none"> <li>-Ensure right dosage, right time and right documentation;</li> <li>-Review Medication Administration Record (MAR) to identify medication to be administered;</li> <li>-Administer within 60 minutes prior to or after scheduled time;</li> <li>-Sign MAR after administered;</li> <li>-If medication is a controlled substance, sign narcotic book;</li> <li>-Correct any discrepancies and report to nurse manager.</li> </ul> <p>2. Review of the facility's Controlled Substance policy, undated, showed staff are directed as follows:</p> <ul style="list-style-type: none"> <li>-The controlled drug record serves the dual purpose of recording both narcotic disposition and patient administration;</li> <li>-Two licensed staff must witness any disposal or destruction of a controlled substance and document same on the Drug Disposition Record;</li> <li>-All controlled drug patches removed from resident are disposed of in such a manner as to prevent diversion;</li> <li>-After removing the patch, the used patch is folded in half so that the sticky side sticks to itself and placed in a Drug Enforcement Agency (DEA)-compliant drug disposal system, so the controlled substance is non-retrievable;</li> <li>-Disposal of patches is witnessed and cosigned on the MAR in the blanks provided with each controlled drug patch order;</li> <li>-Two signatures are required for documentation of controlled drug patch disposal.</li> <li>-Any discrepancies which can not be resolved must immediately reported to Director of Nursing (DON), charge nurse and pharmacy;</li> <li>-Staff may not leave area until discrepancies are resolved or reported as unresolved discrepancies.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265801	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/07/2025
NAME OF PROVIDER OR SUPPLIER  Katy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Prospect Pilot Grove, MO 65276	
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Review of the facility's Medication Error policy, undated, showed staff are directed as follows:</p> <ul style="list-style-type: none"> <li>-Ensure medications are administered according to physician's orders;</li> <li>-Medication error once identified, will be evaluated to determine if considered significant or not by resident's condition, drug category, frequency of error;</li> <li>-Nurse examines the resident's condition;</li> <li>-Document action taken in the medical record;</li> <li>-Nurse reports the incident to appropriate supervisor and completes incident or occurrence report.</li> </ul> <p>4. Review of Resident #1's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/29/24, showed staff assessed the resident as followed:</p> <ul style="list-style-type: none"> <li>-Moderate cognitive impairment;</li> <li>-Received Opioid seven days of the seven day look back period;</li> <li>-Received oxygen therapy;</li> </ul> <p>-Diagnoses of Alzheimer's Disease (progressive disease that destroys memory and other important mental functions), Chronic Obstructive Pulmonary Disease (COPD)(a group of lung diseases that cause airflow obstruction and breathing problems), Respiratory Failure Failure and Renal Failure.</p> <p>Review of the resident's Physician Order Sheet (POS), dated February 2025 , showed physician orders for Fentanyl 72 hour patch, 25 micrograms (mcg)/per hour, change every 72 hours.</p> <p>Review of the resident's MAR, dated 01/07/25 through 02/06/25, showed staff documented they placed the Fentanyl patch on 01/31/25 on the resident's left upper back.</p> <p>Review of the facility's controlled log, undated, showed staff documented they signed out and administered the resident's Fentanyl patch on 01/31/25. Review showed Licensed Practical Nurse (LPN) B signed out a Fentanyl patch on 02/01/25.</p> <p>Review of the resident's MAR, dated 2/01/25 through 02/06/25, did not contain documentation staff administered the Fentanyl patch on 02/01/25.</p> <p>Review of the Resident's Progress Note, dated 02/03/25, showed LPN A documented resident observed on 2/3/25 with two Fentanyl patches with two different dates, hospice and family were made aware. LPN A documented resident appears to have increased confusion, and did not recognize family. Resident was often found sitting in recliner.</p> <p>During an interview on 02/06/25 at 9:35 A.M., LPN A said the resident told the LPN, the resident's arms feel tingly. The LPN said the resident needs his/her Fentanyl patch changed today and the Fentanyl patch, dated 02/03/25, had been placed by him/her on the resident's left shoulder. The LPN said the resident had a fall last night, after midnight.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265801	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/07/2025
NAME OF PROVIDER OR SUPPLIER  Katy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  205 Prospect Pilot Grove, MO 65276	
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/06/25 at 11:26 A.M., LPN A said he/she found the two Fentanyl patches on the resident on 02/03/25. The LPN said one Fentanyl patch was dated 01/31/25 and the other Fentanyl patch was dated 02/01/25. The LPN said at first he/she thought the staff just left the old Fentanyl patch on the resident when they placed the new Fentanyl patch LPN A said he/she started to get concerned when he/she noticed the two Fentanyl patches were dated only one day apart. He/She said the resident had one Fentanyl patch on his/her left upper shoulder and another Fentanyl patch on his/her spine, at the base of his/her neck, right below the resident's Lidocaine patch. He/She said when he/she found the two Fentanyl patches on the resident, the resident did not seem out of it, or he/she would of sent the resident out to the emergency room . LPN A said he/she thought hospice should know, because the two Fentanyl patches was an obvious error. LPN A said hospice asked if they needed to come to the facility on [DATE] and he/she said, he/she actually did not think the resident was acting any different. LPN A said he/she made the Director of Nursing (DON) aware of the two Fentanyl patches. LPN A said he/she did not contact the Medical Director, it was technically a medication error, but it was not his/her error, so he/she thought the DON would notify the Medical Director. LPN A said he/she is aware the resident vomited this morning.</p> <p>During an interview on 02/06/25 at 11:52 A.M., the Medical Director said he/she was not notified about the resident getting an extra dose of Fentanyl. The Medical Director said he/she would want to be notified. The Medical Director said his/her concern with an extra dose of Fentanyl, is the resident could have respiratory depression, weakness, falls, confusion and hypotension. The Medical Director said he/she would consider a resident getting an extra Fentanyl Patch a significant medication error, the resident gets double the dose and Fentanyl is a strong medication. The Medical Director said staff have to look to see where the Fentanyl Patches are placed.</p> <p>During an interview on 02/06/25 at 12:58 P.M., LPN B said he/she did not place the second Fentanyl patch on the resident. LPN B said he/she has been told during report on 02/01/24, the resident did not have a Fentanyl patch on him/her. The LPN said he/she signed the 02/01/24 Fentanyl patch out of the controlled log, but did not administer the patch. LPN B said Registered Nurse (RN) D actually administered the Fentanyl patch to the resident. LPN B said LPN C is the nurse who told him/her in report, the resident did not have a Fentanyl patch on. LPN B said RN D told him/her that they needed to get a Fentanyl patch on the resident. LPN B said he/she did not watch RN D place the patch on 02/01/25. LPN B said he/she thinks the resident receiving two Fentanyl patches is a significant medication error. LPN B said the resident had influenza like symptoms over the weekend, muscle weakness and cough. LPN B said he/she is not aware of the resident having any low oxygen saturation levels. LPN B said he/she should not sign out a Fentanyl patch and let another nurse administer the medication. LPN B said the nurse who signs for the controlled medication, is the only nurse who should have control of the medication.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265801	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/07/2025
NAME OF PROVIDER OR SUPPLIER  Katy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  205 Prospect Pilot Grove, MO 65276	
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/06/25 at 1:20 P.M., the DON said he/she had been notified on 02/03/25 the resident received two does of Fentanyl by LPN A. The DON said LPN A told him/her, when the LPN went to put the 02/03/25 Fentanyl patch on the resident, the LPN seen two Fentanyl patches on the resident, one dated 01/31/25 and the other date 02/01/25. The DON said the LPN told him/her hospice and the resident's family has been notified. The DON said he/she would consider this a significant medication error. The DON said he/she did not notify the Medical Director of the medication error. The DON said the resident had been a little more confused on 01/31/25, so he/she got a urine analysis (UA) done on the resident and tested the resident for influenza, as there has been influenza in the building. The resident tested negative for influenza. The DON said the resident has been running a fever this morning and is flushed. The DON said if nursing staff was checking placement of the patch on every shift over the weekend, the staff would have found the resident had two Fentanyl patches on. The DON said a nurse should not sign the controlled log and let another nurse administer the medication. The DON said the nurse who administered the Fentanyl patch, should have signed the MAR. The DON said if RN D would have signed the electronic MAR, it would have gave a prompt that tells the nurse, the administration was to soon.</p> <p>During an interview on 02/07/25 at 8:42 A.M., RN D said he/she administered a Fentanyl patch to the resident, the morning of 02/01/25. RN D said he/she was told in report, by LPN C, the resident did not have a Fentanyl patch on, because the facility was out of Fentanyl patches and new Fentanyl patches came in over night. RN D said he/she told LPN B, they needed to get a Fentanyl patch on the resident, for the resident's pain. RN D said he/she looked and did not see a Fentanyl patch, before he/she administered the Fentanyl patch. RN D said he/she is not supposed to have control of the Fentanyl patch without signing for the Fentanyl patch. RN D said he/she is aware, he/she did not sign the MAR, he/she was just trying to be helpful to the other staff and get the day started. RN D said he/she was not aware the resident had two Fentanyl patches on.</p> <p>During an interview on 02/07/25 at 8:54 A.M., the administrator said he/she found out about the resident receiving two Fentanyl patches on 02/04/25, by the resident's family. The administrator said the nurse who signed for the controlled medication, should administer the controlled medication. The administrator said he/she would expect staff to inspect the resident's back, before placing a Fentanyl patch. The administrator said the nurse should check the resident's whole back. The administrator said he/she is not sure how the nurses did not see the second Fentanyl patch for two days, when the nurses are supposed to check for Fentanyl patch placement every shift. The administrator said it can be dangerous for a resident to receive double the daily dose of Fentanyl, but the resident's dose was low enough, he/she doesn't think it would cause significant harm. The administrator said if the nurse can't find the resident's Fentanyl patch, the nurses should notify the DON, and go find the Fentanyl patch with another nurse. The administrator said staff should try to find the Fentanyl patch, before placing a new Fentanyl patch.</p> <p>MO00249068</p>		